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WASHINGTON MEDICAL ANNALS

SCHOOL CLINICS.*

By Geo. H. Heitmuller, A. B., M. D.,

Washington, D. C.

Although medical inspection of schools was first established simply to control communicable diseases, it soon was expanded to include an examination for physical defects, and in consequence, reports from many communities began to appear showing that from 80 to 95 per cent. of pupils were suffering from defects, the vast majority of which could be easily remedied.

Progressive communities believing it profitless to pile up statistics of defects, early attempted to procure their removal by notifying the parents, and requesting treatment for the defects found. This method was found to bring about correction in only about 6 per cent. of the cases.

The school nurse was next brought into the problem, and through her activities, visiting the homes and explaining the necessity for treatment, and taking the children to hospitals and clinics, the number of those who received treatment was very decidedly increased, some communities reporting that of those needing treatment, as high as 83 per cent. were receiving it. Other communities keeping careful records were not so successful, for example: Cleveland, Ohio, with eighteen nurses and less than 10 per cent. of the defects found, corrected. So there still remained in all communities a very considerable number, particularly among those who needed treatment most, that received no attention. Especially was this true of defects of the ears, eyes, nose, throat and teeth, these forming the largest proportion of defects found. Communities keeping a vigilant regard upon results, finding that all pupils were still not receiving treatment from private physicians, or at public hospitals and clinics, began to establish school clinics to provide the treatment that could not be procured from existing facilities.

In order to discover how this problem was being handled the Bureau of Education, at the request of the Committee on School Hygiene of the Monday Evening Club, sent to all communities having medical inspection of schools a *questionnaire* covering the essential points; 608 communities replied to the questionnaire with the following results:

* Read before the Medical Society November 18, 1914.

Favoring the establishment of school clinics,	350
Not indicating opinion,	168
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Among those favoring school clinics 66 communities already have established school clinics.

Alabama—Birmingham, for the teeth, hair and skin. Arizona—Douglas, for the eyes ; Tulsa, for teeth ; Phoenix, for the eyes, hair and skin. California—Berkeley, for the teeth ; Long Branch, clinic just starting ; Los Angeles, for ears, eyes and teeth ; Oakland, for teeth ; Sacramento, for teeth. Colorado--Denver, for nose and throat. Connecticut—Bridgeport, for eyes, skin and orthopedic. Illinois—Chicago, for teeth ; Freeport, for teeth ; Decatur, for ears, eyes, nose and throat, skin and hair and teeth ; Monmouth, clinics began April 13, 1914. Indiana—Gary, for teeth. Kansas—Kansas City, for teeth. Maine—Sanford, for eyes, nose and throat, teeth, hair and skin. Massachusetts—Chelsea, for nose and throat and teeth ; Clinton, for ears, eyes, hair and skin ; Fall River, for teeth and tuberculosis ; Brockton, for teeth ; Melrose, for hair and skin, nose and throat ; Plymouth, for teeth ; Newton, for teeth. Michigan—Detroit, for teeth ; Jackson, for hair and teeth ; Muskegon, for ears, eyes, nose and throat, teeth, hair and skin. Minnesota—Chisholm, for ears, eyes, nose and throat, teeth, hair and skin ; Cloquet, for ears, eyes, hair and skin ; St. Paul, for teeth, hair and skin. New Jersey—Englewood, for teeth ; Nutley, for ears, eyes, nose and throat, teeth, hair and skin ; Trenton, ears, eyes, nose and throat, teeth, hair and skin. A psychological laboratory is being organized with the assistance of psychologists from Vineland and Princeton, and hospital for the insane.

New York—Albany, for teeth ; Hoosick Falls, not stated for what conditions established ; Rochester, all conditions ; Schenectady, conditions treated not stated ; Tarrytown, conditions treated not stated ; Utica, teeth ; Yonkers, ears, eyes, nose and throat, teeth, hair and skin ; White Plains, mental conditions, and for teeth this fall. Ohio—Athens, for teeth ; Cleveland, for eyes ; Elyria, ears, eyes, nose and throat ; Lakewood, ears, eyes, nose and throat, hair and skin ; Lancaster, teeth. Oregon—Salem, diseases treated not stated. Pennsylvania—Harrisburg, all classes and conditions treated ; Jeannette, ears, eyes, nose and throat, teeth, hair and skin ; Monongahela, eyes ; Reading, ears, eyes, nose and throat, hair and skin ; Williamsport, for teeth. Rhode Island—East Providence, ears and eyes ; Newport, eyes and teeth ; Providence, eyes. Utah—Provo, for teeth. Washington—Tacoma, all conditions. Psychologist from State University assists with abnormals. Wisconsin—Milwaukee, for teeth.

District of Columbia—One room equipped for eye clinic where the Medical Inspector examines all children in special schools and prescribes glasses where required ; also some pupils in regular classes. Dental clinic services given free by members of Dental Society two hours a day by two dentists, who treat about five pupils a day ; the object of this voluntary service is to demonstrate the need and benefit, so that the community will provide adequate and paid service.

Forty-six communities have clinics for treating the teeth ; 30 for treating the eyes ; 23 for treating the hair and skin ; 20 for treating the ears ; 19 for treating the nose and throat ; 1 community has a clinic for treating mental cases ; 1 for treating orthopedic cases ; 1 for treating tubercular cases.

Ten communities employ physicians full time, and pay from $1,200 to $2,000 per year ; 23 communities employ physicians part time, and pay from $0.50 a treatment to $5 per hour for

oculists, and $3 per half day for dentists. Yearly salaries for part time range from $200 to $1,200 for 3½ hours per day.

Hoboken, N. J.—Supt. A. J. Demarest reports that Hoboken has medical and dental clinics; they were established so that school hours would not be interrupted. Glasses are furnished free to the indigent by philanthropic persons (this is true in most cities supplying glasses, only a few school boards supplying glasses). There is no psychological or anthropometrical laboratory, only the Binet tests are made by medical inspectors. There is every reason to believe that school efficiency and retardation are benfited by school clinics. In the medical clinic 395 pupils were treated, receiving 812 treatments; 104 pupils receiving treatment for nose and throat conditions, including 67 operations for removal of adenoids and tonsils; 66 pupils received treatment for conditions of the skin and hair, 64 for eyes and 18 for ears; 143 for various conditions from adenitis to verruca.

In the dental clinic during the school year 1912–1913, 1,132 pupils received 2,608 treatments. Extractions, 2,446; fillings, 2,060; cleanings, 1,260; abscess cases, 255. All pupils may avail themselves of free treatment.

The total cost for examining 9,035 pupils and the treatment for all conditions together with the nurse and supplies amounted to $6,286.38, a per capita cost of $0.59. School clinics should be encouraged and should be free.

New York City.—Dr. S. Josephine Baker, Director of the Bureau of Child Hygiene, reports that New York has medical and dental clinics. They were established because of inadequate facilities, and while not specifically established to conserve the school time, they meet this need. It is impossible to determine how many children receive treatment at the public hospitals and clinics. Glasses are furnished free by arrangement with the social service agencies.

In the school clinics 10,381 pupils were refracted; 12,603 were treated for contagious eye diseases; 6,937 received treatment for nose and throat conditions, and 7,257 were treated for the teeth.

The physicians receive $100 per month and serve 3½ hours per day excepting Sundays and holidays. New York has no psychological and anthropometrical laboratory. School efficiency and retardation have both been benefited by the school clinics and they should be encouraged and be free.

Philadelphia, Pa.—Dr. Walter S. Cornell, Director of the Division of Medical Inspection of Schools, reports as follows: "The City of Philadelphia maintains four dental clinics and two eye clinics for school children. The municipality finances these. The main eye clinic and the main dental clinic are situated in the City Hall, the others in public schools, the Board of Education donating the room and the general facilities.

"The dental clinics are established because of the almost ab-

solute lack of dispensary facilities in the city. We have three dental colleges, but experience has shown that the dental students have not time to do the routine work required, nor was it done satisfactorily, nor were even a small proportion of the cases handled. The dental clinics run morning and afternoon without regard to school hours. The eye clinics run in the afternoon hours without regard to school hours.

"The greater proportion of dispensary cases (aside from dental work) are treated at the free dispensaries of the numerous hospitals in Philadelphia. A computation was made of such cases for the last annual report, but it was found to be incorrect owing to the computing method not taking into account transfers of children. Approximately 15,000 children received treatment at public dispensaries, mostly at the dental clinic of the Douglas Hospital; a small number, probably 800, were treated for diseases of the eye at general dispensaries. The skin cases were mostly treated by the school nurses. The hair cases were sent home for treatment.

"Glasses are not furnished free except to those children receiving their prescriptions at the municipal eye dispensary mentioned above. There were 2,278 pairs of eyeglasses furnished by this municipal dispensary last year. The children in question were all certified to be indigent. The city, not the Board of Education, paid for these eyeglasses. Approximately three-fourths of the cases were public school children and the remaining one-fourth parochial school children.

"The City Eye Clinic (and branch) treated in 1913 3,208 cases. The City Dental Clinic and its three branches treated in 1913 12,218 cases."

"The chief of the City Eye Dispensary receives $2,500 for at least three hours a day; the assistant at the branch eye dispensary receives no salary. The clerk to the chief receives $800. The chief of the Dental Dispensary receives $2,500; twelve assistant dentists receive $700 each for three hours per day; the clerk receives $800.

"A weekly clinic for the examination of mentally-deficient children is held. It is not a research laboratory. In 1913 225 cases were examined.

"We have no absolute evidence that these school clinics have increased the efficiency of the pupils treated, but we believe such to be the case. The same is true of retardation.

"This matter of school clinics is only a part of the great general question of socialized medicine and the other great question of the proper conduct of our general hospitals and dispensaries. Whether medicine should be socialized as it has been in Great Britain is an open question. Probably it would be a good thing. Assuming, however, that such socialization is too far in the future and that a practical discussion must deal with the present general

system, I thoroughly believe that the great advance in procedure will lie in the reform of our ordinary hospital dispensaries. Our present school clinics are really a feeble protest against the illogical and inefficient methods now prevailing.

"If our general hospitals were to confine their free dispensary treatment to the indigent only and were to pay the dispensary physicians as medical inspectors and physicians in school clinics are paid, the school clinic probably would be reduced to a fraction of its present size."

Boston, Mass.—Boston has no school clinics. Beginning June 1, 1914, a special dental clinic is at the disposal of the school board for the care of the teeth of all school children. This institution, the Forsyth Infirmary, is a private endowment and is to be free for all children sixteen years of age and under.

The following communities have psychological and anthropometrical laboratories for the study and treatment of abnormal pupils: Oakland, Cal.; La Salle, Ill.; Charles City, Iowa; New Orleans, La.; Leominster, Mass.; Vineland, N. J.; Eau Claire, Wis.

The reason given for establishing school clinics in the vast majority of cases is inadequate or non-existing facilities; in several cases it is to conserve the school time of the pupils, and in one case it was established so that the school could control the facilities for treatment.

The inquiry shows an almost unanimous opinion in favor of advancing to the next stage in the development of school hygiene, the school clinic. There can be no question that this will work to the welfare not only of the school but to the community as well, particularly in the years to come.

The one weakness in some of the communities having school clinics that is liable to lead to poor results and to their abandonment is the fact that the services of the physicians are rendered without being paid. The same outcome is to be expected in the school clinics as resulted in the cases where medical inspection was established without paying the inspectors; at first they worked with great enthusiasm and the results were splendid, but in course of time the work became less interesting and it suffered, the school officials became indifferent and thought and said "medical inspection does not amount to much anyway," and it was abandoned, and the schools were deprived of the great benefit that is patent and testified to by every school superintendent who has an efficient medical inspection service.

One director of medical inspection thinks the school clinic is a matter of medical economics and appears to think that reforming the public hospitals and dispensaries will meet the need of the school clinic, which he regards as a feeble protest against the illogical and inefficient methods of the public hospitals and dispensaries.

It is only necessary to reply to this view that the school clinic has its greatest development in the largest cities where the public hospitals and dispensaries are most numerous and presumably most efficient, and that while the school clinic may secondarily be a matter of medical economy, primarily it is an educational question relating to school hygiene and efficiency, and it should therefore be under the actual control of the School Board and not under the Board of Health or some voluntary association.

Coming now to the situation in this District, it is necessary to estimate the number of the various classes of cases that will be found in need of treatment upon the establishment of an efficient medical inspection service, in order to provide for their treatment.

Thomas Denison Wood, in an article read before the American School Hygiene Association in 1912, states that from a careful study of statistics he finds that of all pupils, over 5 per cent. have defective hearing, about 25 per cent. have defective vision, over 30 per cent. have enlarged tonsils, adenoids, etc., and over 50 per cent., in some schools 98 per cent., have defective teeth.

We will therefore find among the 55,000 pupils in the District, 2,750 cases of defective hearing; 16,500 of tonsils, adenoids, etc.; (19,250 total ear, nose and throat cases); 13,750 cases of defective vision; 27,500 of defective teeth at least; hair and skin cases about 3,000.

To determine how many of these cases can be treated in the hospitals and dispensaries of the city the committee communicated with the heads of the various departments of all the hospitals and dispensaries, inquiring how many of the various classes of cases could be treated in addition to the regular number now treated.

The following table gives the capacity of the existing facilities:

Hospital.	Eye cases per week.	Ear, nose and throat cases per week.	Hair and skin cases per week.
Casualty	10—20	10—12	15
Children's	00	00	60
Emergency	10	40	15—30
Episcopal Eye, Ear and Throat	50	50	00
Freedmen's	20—30	100	20—30
Georgetown	10—15	10	15
George Washington	10	10—12	20—30
Homeopathic	10—12	12—16	20—30
Lutheran Eye, Ear and Throat	50	50	00
Providence	10—12	10—12	15
Washington Eye, Ear and Throat	10	8—10	00
Total per week	219	312	225
Total per school year	8,760	12,480	9,000

From an inspection of the number of cases and the table showing the capacity of the hospitals and dispensaries, it will be seen that approximately two-thirds of the eye, ear, nose and throat cases, and all of the hair and skin cases can be treated at the existing institutions. Existing facilities for treating defective teeth are absolutely inadequate to treat even the smallest proportion of such cases.

In order, however, to make use of the services of the hospitals and dispensaries a certificate signed by either a physician, a member of the Board of Charities, one of its agents, or a visiting nurse, is required, showing that the bearer is unable to pay for the services. Granted that these certificates are forthcoming in every case, it will require a system providing for the most careful cooperation between these institutions and the schools, so that there will always be the proper number of cases in attendance at the clinics, and a systematic report to the schools showing which pupils have been treated and which failed to appear for treatment, in order to prevent the leakage between the school and the clinics that has been so much in evidence in other communities.

Even under the most favorable circumstances at least one-third of eye, ear, nose and throat, and practically all the teeth cases will remain untreated. The establishment of school clinics for the treatment of these cases is a necessity that must be urged at once, unless one-third of the work of an efficient medical inspection service is wasted, to say nothing of the economic loss resulting from the retardation of the untreated cases. This loss is demonstrated by Dr. Louis C. Wessels, the ophthalmologist of the Philadelphia school system, in an article entitled "Defective vision in school children from an economic standpoint," read before the Fourth International Congress of School Hygiene, at Buffalo, in 1913. Dr. Wessels says "The cost of a year's tuition in Philadelphia is about $35. From January, 1908, to January, 1913, the writer examined in the City Hall Clinic 8,167 school children and refracted under a mydriatic 7,319 and furnished free 6,319 pairs of spectacles. Out of 7,319 cases refracted, 5,211 or 72 per cent. were backward, representing a composite loss of 11,831 years, or a money loss of $414,685. We now refract over 2,500 cases a year. If we save each one of these children but one year during its entire school life we will save the city over $87,000 annually, not counting the child's time and its increased efficiency. So the furnishing of free glasses to school children is not a charity *per se*, but is a duty and an economic problem."

The question whether treatment and glasses should be free shows a great diversity of opinion, with perhaps the majority in favor of it being free to all. For the best interest of the child and the community it would seem best to have all treatment and glasses free. If an attempt is made to force parents or

guardians to pay for such services, immediately the question of treatment by family physicians comes up, delay follows delay, and in most instances nothing will be done. In those communities where books are not furnished free, much time is lost in each year to many pupils and, of course, much money to the community, by reason of not having books until long after the beginning of the school term. The same result would follow if treatment and glasses were not free in the school clinics.

The advantages of school clinics have been summarized by Cruikshank in his book "School Clinics at Home and Abroad."

The committee takes this opportunity to thank Dr. P. P. Claxton, the Commissioner of Education, and Mr. Frederick A. Cleveland, the Director of the Bureau of Municipal Research of New York City, for valuable aid and suggestions, and the chiefs of the various departments of the local hospitals for their cheerful willingness to treat free 30,000 cases in addition to the large amount of free treatment they now give.

Dr. E. L. Morgan said that all medical charities commence with good intentions; hospitals begin so, but with the years there is always an increasing percentage of free treatments, out of all proportion to the indigent population. The establishment of school clinics will operate to increase the evils of dispensary abuse, and this is already a grievous enough problem. If medical charities must be maintained then the State should pay for every bit of charity the doctor gives. For his part he could see no more reason for furnishing medical attendance to school children by the State than for its paying the parents' house rent.

Dr. Isabel Haslup Lamb said that while house rent is not paid by the State, in many schools in many different localities food is given to children at public expense; the principle involved is the same in both cases. The paper was a very timely one; it may as well be accepted that the school clinic will come and will endure.

Dr. Macatee said that the effect of school clinics upon the medical profession is a debatable question and one fraught with as many difficulties to solve as the free dispensary problem. But it is a matter that is very apt to be settled outside the profession, and in spite of it, and for the reason that the profession and ordinary organized medical charity do not meet the needs of the situation. The teaching profession is naturally made up of a very intelligent body of people, and they are thoroughly indoctrinated with the relationship between bodily handicap and educational retardation; when, therefore, after the medical inspector has discovered that a pupil is suffering from a remedial defect and advises the reference of the child to the family physician, and the family physician treats adenoids indefinitely with sprays or administers treatment to absorb hypertrophied tonsils or advises

that the child will outgrow cross eyes, then the suggestion of a school clinic where real things will be really done is almost inevitable.

Dr. John D. Thomas said that what Dr. Macatee had said was true in some respects, but in his opinion in most instances the parents of a child are better judges of what is good for the child than are school officials. There are constitutional rights involved in this question and in many other modern sociologic ideas. The enthusiasts for school betterment sometimes forget that the foundation of every good state is the home. In the matter of school supervision of treatment of physical defects of school children some middle ground could and should be reached where the rights of the parents and the good of the children might be preserved.

Dr. Heitmuller remarked that in the course of time Dr. Thomas will probably find cause to revise his opinions. He replied to Dr. Morgan that he is far from proposing that clinics for school children shall be conducted on the basis of free services of physicians. He believes that physicians engaged in this or in any other form of public medicine should be paid and paid well for their services.

CHRONIC GONORRHOEA.—REPORT OF A CASE.*

By Adam Kemble, M. D.,

Washington, D. C.

In October, 1913, I read a paper before the Therapeutic Society advocating the more liberal employment of the complement-fixation test in the diagnosis of chronic gonorrhoea. In January, 1914, before the George Washington University Medical Society, I again advocated its use. Objection was raised that frequently a positive reaction is obtained when all reason demanded that a negative be found. The following case would no doubt be classed as one of these. In the spring of this year I was greatly tempted to report this case as a vindication of the value of the reaction, but on reflection decided to await the result of treatment.

Male, age 36. Referred to me in February, 1914, by Dr. E. G. Seibert. Had a very mild attack of gonorrhoea in 1908 which cleared up very promptly under local treatment. Never had any recurrences. He was never satisfied that he was well, and took several courses of prostatic massages by different surgeons and was assured in each case that no vestige of the disease remained. For the past several years he has been extremely anxious to get

* Reported to the Medical Society November 25, 1914.

married, but the fear of imparting the disease has caused the repeated extension of his engagement. The presence of a few shreds in the urine greatly disturbed him.

On examination the external genitalia were found to be normal. The first glass of urine was clear with a few shreds, the second glass was clear and the third glass showed a considerable quantity of spermatic fluid and a few pus cells. The prostate was small and irregular in outline. Indurations were found in both upper poles. The vesicles were distinctly palpable and indurated, and were bound together by a firm band of adhesion. Strong adhesions bound the prostate and vesicles to both pubic *rami*. The expressed secretion contained a moderate number of pus cells with small quantities of lecithin and many active spermatozoa. No gonococci could be found.

Two days later urethroscopy disclosed a greatly enlarged and congested verumontanum with a small papillary growth on its upper surface. The urethra was otherwise normal.

The prostatic secretion was carefully examined a number of times and no gonococci were discovered. Appropriate treatment was directed to the verumontanum which quickly became normal.

March 8th I advised a complement-fixation test for gonorrhea which proved to be positive. Having no doubt then as to the presence of gonococcus I assumed it to be located in the prostate and vesicles. Treatment was immediately commenced. Frequent prostatic massages followed immediately with deep injection of 15 per cent. solution of argyrol were employed until the end of the treatment. An intensive course of gonococcic vaccine was given. Five days after the second injection of vaccine the expressed secretion from the prostate and vesicles discovered quite a quantity of pus which was loaded with gonococci. These organisms had all the staining properties and morphological characteristics of the gonococcus. At no time since could I discover any of these organisms.

July 21st the complement-fixation test for gonorrhoea was negative. October 5th negative again. The pus had disappeared from the prostatic secretion and lecithin was present in abundance.

An Englishman, talking against many things in America, happened to say to a friend in New York: "Why, even your newsboys can't take a joke!"

The American friend replied: "Just try the next one that comes along with some nonsense and see if he can't answer you."

The Englishman agreed and stepped up to a newsie, saying, "Hello, youngster, look at your nose and tell me what time it is."

The boy quickly replied, "Aw, look at your own, mine ain't running!"

RADIOGRAPHIC GASTRO-INTESTINAL DIAGNOSIS.—A NOTE OF WARNING.*

By J. Russell Verbrycke, Jr., M. D.,

Washington, D. C.

The improvement in the art of making and interpreting radiograms of the digestive tract, has been of inestimable value in promoting more exact diagnosis of pathological conditions in this part of the body. The radiographic examination is perhaps the greatest single diagnostic method which we have at our disposal. The radiographer and the gastro-enterologist know, however, the limitations of this method at the present time. They know that the x-ray examination is only part of the whole diagnostic scheme.

The writer has noticed a growing tendency of physicians to send patients to the radiographer for a diagnosis to be made unaccompanied by a history of the symptoms and without the other important examinations and tests being made. One roentgenologist has told the writer that over half of the patients come to him in this way.

Such a state of affairs is distinctly unfair to both the patient and the radiographer. The latter is handicapped by two things, first by the fact that many cases show negative or inconclusive findings, and second, by the difficulties of interpretation.

In the last 75 cases of the writer which have been radiographed the examination was normal in 8 cases and corresponded to the clinical course; in 12 the examination was of no service in the diagnosis; in 43, the largest number, definite results were secured, which, taken with the other symptoms and signs, were of great value, while in only 12 cases would the radiograph have disclosed the lesion present without any further examination.

As to the difficulties of interpretation it must be remembered that in spite of the fact that the radiographer is using his eyes, the keenest and most reliable of the senses, he is not viewing the lesion directly, but rather shadows and silhouettes. It is easy for the eyes to convey wrong impressions to the brain in the everyday world and there is greater room for error with this sort of vision.

Again, one does not usually see the lesion itself but more often results produced by the lesion, sometimes anatomic, again functional. In a duodenum ulcer we may not see anything wrong with the shape of the duodenum but may see exaggerated peristalsis and hypermotility only. We do not see the colitis which has produced pericolitis with adhesions, but can only note the constriction of the bowel and immobility. In gastric ulcer we

* Read before the Medical Society November 4, 1914.

may see a niche or bud, produced by the bismuth filling the crater of the ulcer, a direct anatomical finding. This, if present, is the only pathognomonic sign of ulcer of the stomach, but more often we find only a spasm, incisura or otherwise, a functional result of an anatomic lesion which we cannot visualize.

So that it may be seen that for a radiographic examination to be of value one must not only be able to interpret what has occurred to give such and such appearance on the screen or plate, but must be able to apply the findings to the particular case, fitting in the radiographic findings with the symptoms, tests and signs of the clinician, to make a diagnosis from the whole.

The question arises who should make the diagnosis: Not the clinician alone nor the radiographer alone, but by both reviewing the clinical findings and the plates together. Each must, of necessity, know something of the work of the other. The radiographer must have a knowledge of the functioning of the digestive tract in health and disease, the shapes, sizes and positions that approximate normal. The clinician should at least be able to recognize the routine findings when pointed out to him, and with experience will be able to go further and himself interpret somewhat.

The ideal way is for the clinician and radiographer to not only review the plates together but to make the fluoroscopic examination together, with an upright screen. The attending physician is supposedly familiar with the patient's symptoms and signs. He can put his finger on the tender point, if any, and it can then be visualized to determine what organ is at fault, etc.

Again let me emphasize the point that it takes the combined resources of the clinician and radiographer to make the maximum number of correct diagnoses in gastro-intestinal disease, and then even under the most ideal conditions there remain a considerable number of doubtful cases.

We will now consider briefly some of the findings in a few conditions.

Oesophageal Cases.—I have remarked before that I believe the oesophageal cases give us our largest percentage of absolute diagnoses from the radiographic examination, *per se*. The findings are favored by the fact that the oesophagus is a tube fairly well fixed and more invariable in size, shape and position in different individuals than the rest of the digestive tract. Variations from normal are easily made out. I do believe, however, that it is often impossible to make an absolute differentiation between benign and malignant constrictions.

Colon Cases.—The colon is the next most favorable part for x-ray examination. There are wide variations in the normal, but still it can be determined if motor functioning is normal. It is rather astonishing to note that hardly any two persons have the colon exactly alike. The length and diameter vary greatly, the

various flexures may be in different positions and of different shapes; there may be a short, nearly straight, sigmoid, or it may be coiled on itself several times, and yet the bowel may functionate perfectly.

The radiographer can note pretty definitely, however, by a combined fluoroscopic and plate examination, the presence of new growths, adhesions, kinks, ptosis, etc. The fluoroscope, with manipulation, is a necessity for this work, and if the examiner be not equipped for this manipulation in upright and prone positions one cannot depend on getting results.

Stomach Cases.—By all odds the cases in which the radiographer needs the services of the clinician the most are the stomach and duodenal cases. The radiographic findings upon which diagnosis can be made alone without question are rare. Difficulties of interpretation are legion. The spasms about the antrum and duodenal cap are more or less incapable of explanation when considered alone. We know that they indicate a reflex from some lesion, either in the immediate vicinity or far away, perhaps an ulcer of the stomach, duodenum, an appendix or gallbladder conditions, so that we know little more than before. If, however, occult blood has been present, with hyperacidity, we can be certain that the lesion is an ulcer and then the radiographic examination becomes valuable in confirmation. If there is vigorous peristalsis and rapid emptying it is probably duodenal. If a tender point can be visualized on the screen to be over the stomach there is probably gastric ulcer. If acid in the stomach be subnormal or absent, and still there is occult blood and the spasm noted, without anatomic defect, it is more apt to be hemorrhagic gastritis due to gallbladder or appendix inflammation. This merely serves to illustrate how the clinical and x-ray findings must be correlated.

There are few pathognomonic findings in digestive radiographic work on the stomach. Let us take for example ulcer on the lesser curvature of the stomach. In a series recently studied by the writer seven different findings were noted. In a few cases absolutely nothing may be demonstrated. We may see the niche or bud coming off from the main bismuth shadow, caused by bismuth filling the crater of a penetrating ulcer, the only infallible finding of ulcer, and this cannot be said to be absolutely without chance for error, for it is possible for the duodenum to curve up behind the lesser curvature, and a bit of bismuth in this part of the duodenum to be seen, which looks looks like a bud from the stomach itself. I have seen this occur three times.

We may see an incisura or spasmodic notch in the greater curvature, a very valuable corroborative sign but not absolutely pathognomonic. Again, there may be a real organic hourglass contraction; this is a definite finding. Again, there are cases in which there is a broad, spasmodic contraction completely around

the stomach. A six-hour residue has significance. Another finding is the left-sided drain-trap stomach supposedly due to contraction of the longitudinal fibers. Lastly, there are the baffling spasms of the antrum and duodenal cap. Let me repeat that all of these varied findings are possible with the ulcer in exactly the same position on the lesser curvature.

Cancer of the stomach is supposed to give rather characteristic findings, a worm-eaten finger-print appearance of the part showing defect in filling. I believe that a negative radiographic examination can certainly rule out malignancy, but unhesitatingly say that without complete clinical examination it is possible to make grave errors in diagnosing cancer. I will later show plates from a case very typical of cancer. Under rest in bed for a week the occult blood disappeared. This does not happen with cancer, so it resolved itself into a question of the relative value of these tests. Six months later other pictures were made and this part of the stomach was normal, but there was a marked incisura high in the greater curvature.

I have also seen plates from a patient of another physician in which there was evidence of a large infiltrating growth in the stomach, typically carcinomatous. Plates at intervals for some weeks showed progressive encroachment of the growth on the healthy stomach. It was diagnosed inoperable carcinoma, when suddenly the patient began to gain in weight, which would be a surprising thing for advanced malignancy, and a Wasserman test was made. After being returned double plus, salvarsan was administered and the next set of pictures was remarkably different.

These remarks are made not to discountenance the radiographic examination. It is a wonderful aid to the diagnosis of digestive disorders, and if my patients could afford it I should have them all examined by the radiographer. Nor do I wish to discourage any from employing the x-ray in the diagnosis of digestive disorders. But, I do wish to sound a warning against attempting to let it take the place of a careful, clinical examination, and expecting the miraculous.

The work is in its infancy, but even when greatly perfected it will not supplant the other methods of examination but will add to them its wonderful help.

Dr. Groover said that the note of warning given by Dr. Verbrycke was identical with that being sounded by conscientious radiographers all over the country. Unquestionably clinicians and roentgenologists should work in harmony in the study of these cases and should seek to interpret the plates by collaboration.

Dr. Selby thanked Dr. Verbrycke for the paper. Dr. Selby had long been of the opinion that the attitude of the clinician and the roentgenologist in the study of gastro-intestinal disorders

should be absolutely coöperative. He holds the opinion that the fluoroscope is of the greatest value and importance in the study of these cases, and while the making of plates is a useful adjunct plates alone cannot supplant the fluoroscope. The proper coöperation cannot be had very often because the clinician is in too great a hurry. A fluoroscopic examination cannot satisfactorily be made until after the operator has been in the subdued light of the laboratory for from ten to twenty minutes. Usually the clinician comes in hastily from the bright sunlight and is apt to be impatient at his inability to see the fluoroscopic images that the roentgenologist is describing, and naturally asks for more x-ray illumination. This means the use of a stronger current than is safe to use for more than a few seconds. The use of excessive currents for fluoroscopic examinations, and the tendency to prolong observations in order to determine some debatable point, are both extremely dangerous. There will be burns to account for unless these points are guarded against.

MYIASIS OF THE URINARY PASSAGES. ABSTRACT.*

By Ernest F. King, M. D.,

Washington, D. C.

Myiasis is the general term applied to the occurence of dipterous larvae in man, and the larva most frequently found is that of the *Fannia scalaris*, the small fly frequently seen in spring, darting actively about under chandeliers and other pendant objects. It is also known as the "latrine fly" from its favorite resort. This fly lays its eggs in dark, moist places, and the larvae may appear in from one to eighteen hours, depending on the warmth of the place of deposit. The larvae are full grown within from six to twelve days, but under favorable conditions three or four weeks may elapse before they enter the pupal stage.

The literature on the subject is limited and the library of the Surgeon General's Office gives but few titles. Osler's Practice devotes a page to Myiasis but does not mention its occurrence in the urinary passages, and Stiles, in Vol. II of Osler and McCrae, has only a few lines on the general subject.

Captain P. S. Lelean (*Br. Med. Journal*, 1904, I, p. 245) collected a series of thirty cases of myiasis. The first known was described in 1582 by Ambrose Parè. In most of the cases the larvae were believed to be those of *Fannia scalaris* (formerly *Homalomyia*). One curious story I will cite. In 1842 an eminent London physician wrote, "I saw hundreds of worms escaping

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from the skin of her body. The carpet was covered with them where she stood dressing. They had the power of ejecting themselves to a distance of twelve to twenty inches.''

In 1899 Lieut. Col. Smith saw a dipterous larva spring three feet. The saltatory accomplishments of the ordinary cheese skipper will be recalled.

Cipriani (*Il Morgagni*, 1902, 44, p. 384) reports the case of a woman vagrant, age 64, badly constipated, who passed quantities of dipterous larvae from the vagina. A recto-vaginal fistula existed. The author believed that the eggs had been deposited on food and had hatched in the rectum where the hard, fecal masses present had aided the larvae in producing an ulcer which perforated the recto-vaginal septum, allowing the passage of the larvae into the vagina.

Rene Chevrel (*Arch. de Parasit.*, 1909, No. 3) makes a careful analysis of all reported cases of myiasis of the urinary passages and adds a case of his own. Twenty such cases have been reported, six of which he regards as authentic, ten as probable and four doubtful. His own case makes seven which are authentic.

The eggs of diptera may be deposited on sounds and thus carried to the bladder, or in catheters or in water used in irrigating the bladder, and thus eggs or resulting larvae introduced into that viscus. Generally, however, he thinks that the ova are deposited by the fly about the meatus urinarius where are found the conditions favoring their growth, namely, darkness, moisture, warmth, oxygen and food, which last is furnished by a gonorrhoeal or other albuminoid discharge.

The young larvae pass into the urethra and on into the bladder, seeking food. They require but little oxygen, and in the author's experiments were kept under water for hours, becoming active when taken out. There is always some air in the urethra and probably in the bladder.

The contamination is favored by sleeping without cover in hot weather, flies having free access to the genitals and anal region. Women, wearing longer gowns than men, are less affected. On the other hand, women and children without proper underclothing are more liable to infection.

Chevrel's own case was that of a paralytic, wife of a farm laborer, who was left alone all day on a chair that had been transformed into a commode by removing the seat and winding the framework with rags, and placing a receptacle for the dejecta on the floor, flies swarming at will about the buttocks and genitals. She passed larvae daily with her urine from May 19th until into July.

Author's Case.—Oct. 29, 1914, H. P., age 32, living on a small farm in Virginia, whom I had seen at my service at Emergency Hospital, brought to my office an object that he had passed with his urine and which was later identified as a larva of *Fannia scalaris*.

The patient had had a chronic urethritis for several months and had the habit, when at home, of urinating in a glass and observing the urine. The glass he kept in a shed back of his house, turned upside down on a shelf, and it was always rinsed after using. He had been making urethral injections with a small, hard rubber syringe which he kept wrapped in paper and in a closed drawer, so that apparently the larvae could not have been in the glass nor the eggs or larvae in the syringe.

On the morning in question he was digging potatoes in his garden when he was seized with an intense desire to urinate. He barely had time to get to the shed, felt something passing with the urine and saw the larva in the glass. When I received it two hours later it was fresh and perfect in every respect.

He has seen no more larvae since this one appeared, nor has he been able to find them in the bowel dejecta after diligent search.

The patient has been troubled much with constipation and the infection probably took place while seated long at stool, the eggs hatching promptly and the larvae working their way up the urethra in search of food. The injection he was using may have removed some while still small, and, on the other hand, may have aided some on their way toward the bladder.

I believe that the patient's word may be trusted, and that we have here the eighth authentic case of myiasis of the urinary passages.

I am indebted to Dr. L. O. Howard, entomologist of the U. S. Department of Agriculture, for the identification of the specimen and for the copy of Chevrel's article.

Dr. L. O. Howard said that Dr. King had presented, in his opinion, a very perfect case of myiasis of the urinary tract. The fact that the patient was a farmer of constipated habit and accustomed to sit long in an ordinary country privy formed ideal conditions. The *Fannia* is a frequenter of privies and may breed in human excreta. The fly, under such conditions as these, could easily lay its eggs at the meatus urinarius; the temperature conditions would cause them to hatch speedily, and the larvae could find their way easily into the urethra and possibly even into the bladder.

Dr. O'Malley said that while she had seen several cases of this disease, one case in particular occurring in a woman suffering from a manic progressive psychosis was of special interest. When she was in an excited state she was exceedingly untidy in her habits, and on one occasion while in this condition hundreds of these larvae were found on the vulva. They had entered the rectum, vagina and bladder, and while there was no difficulty in removing them from the rectum and vagina, yet it required irrigations of the bladder for at least a week before she was rid of them.

Dr. Hagner inquired if it were not unlikely that there would be only one larva if the infection had been acquired as suggested?

Dr. R. A. Hooe said that it seemed remarkable that such an invasion of the bladder and urethra could occur without evidence of cystitis or of urethritis.

Dr. W. P. Carr asked Dr. Howard how long it takes fly larvae to develop? He had frequently shot birds and after leaving them in the sun for a few hours had found them covered with maggots. The maggots were able to jump several feet,

Dr. Howard said that the larvae seen by Doctor Carr on dead birds were the larvae of some flesh fly. Many of these flies do not lay eggs, but deposit living larvae. These larvae are more or less saltatory in their habit, just as are the common cheese skippers (the larvae of *Piophila casei*), which are occasionally found in cases of myiasis intestinalis.

Dr. King replied to Dr. Hagner that the specimen exhibited was not the only larva passed by this patient. He had voided similar objects on Oct. 19 and 28, but had not brought them to me, thinking that I "would laugh at him." To Dr. Hooe he replied that the patient had suffered from vesical pain and from urgency of urination since January, 1914.

AN UNUSUAL CASE OF ANAPHYLAXIS FOLLOWING THE ADMINISTRATION OF TETANUS ANTITOXIN.*

By Dwight Gordon Smith, A. B., M. D.,

Washington, D. C.

It is not my intention to enter into a didactic or academic discussion of anaphylaxis as a pathological entity, but merely report a case of this condition and of unusual type. Anaphylaxis following injections of tetanus antitoxin has probably been observed by all of us, but bearing in mind the thousands of injections of antitetanus serum made, we can readily see that anaphylactic shock is of comparatively rare occurrence.

Nocard, who treats all cases of tetanus by the administration of enormous doses of antitoxin, "multiple injection" he terms them, says he has never seen a case of anaphylaxis. Sir William Osler administers the antitoxin in doses of 3,000 units each, every three hours, and says that anaphylactic shock is uncommon in his experience. But it does occur, and if this had been an ordinarily severe case of it I would not make this report to night. The case history is as follows:

*Read before the Medical Society November 4, 1914.

R. E., female, white, seven years of age; had always enjoyed good health, never having had urticaria or any *other* form of *skin* disease. July 20 of this year she fell from a porch and cut her hand on some glass which was lying on the ground. The wound was a ragged one, extending almost the full length of the third finger of the right hand along the palmar surface. When I saw it it was full of dirt. I cleansed the injury thoroughly with sterile water and antiseptics, and then dressed it. An hour after the injury, according to my invariable custom in such cases, I injected 1,500 units of tetanus antitoxin in her back between the scapulae. For nine days she did well, resuming her play and usual mode of life. Her appetite and general health were good. The wound looked well, healing slowly but satisfactorily for such a severe lesion.

July 30, the tenth day of the injury, I was called to see her. Her back, thighs and breast were covered with a bright, red rash. The appetite was poor, the patient languid, temperature normal, and absolutely no throat symptoms whatever. The tongue was covered with a heavy, greyish coating. 31st the rash had spread to the face and extremities and now covered the entire body. In addition to this rash, which served as a background as it were, there were large wheals scattered over the the breast, extremities and face, giving the latter a startling appearance. The itching of the wheals was very severe, and caused the little patient much suffering. Otherwise she was feeling fairly well, her appetite had returned, and she expressed a desire to get up. Aug. 1 she was evidently very much better, rash rapidly disappearing. 2d, rash had now completely disappeared, but she was *still* a little weak.

Aug. 3d, her condition was normal in the morning, but toward the afternoon her face became oedematous and eyelids puffy. 4th, the face was slightly swollen in the morning, but decidedly so toward night, so that she presented a very odd appearance. The amount of urine voided *per diem* was normal, and the analysis showed nothing of pathological import. 5th, her face was swollen in the morning, and more so in the afternoon ; feet and hands swollen very little if any. 6th, swelling worse in afternoon than morning, otherwise she felt well and played out of doors. 8th, swelling still persisted. In the afternoon she left Washington for a town in Ohio. When she left the urine was normal in amount, chemical components and microscopically. The digestive, circulatory and respiratory systems were all normal.

From this point on I must depend on notes furnished me through the courtesy of her mother. Aug. 9th, while on the train she was suddenly attacked by a severe pain in her knees and also nausea and fever. Greatly alarmed, her mother sent for a physician on arriving at her destination. The patient's knees were swollen and tender to the touch and her suffering most acute.

Her temperature was 104 and was accompanied by nausea, prostration and delirium. 11th, temperature varied from 101 to 104 in afternoon, and was attended by sweats and prostration. She complained of pain in both legs and said she could not move them. This immobility was probably due entirely to the pain; urine normal. 13th, temperature ranged between 103 and 104 nearly all day. She was delirious, and when she was conscious she complained of pain in her knees, legs, thighs and ankles. 13th, knees slightly better, right ankle painful and tender to the touch, left ankle affected. On account of the immobility due to pain the mother feared paralysis had set in. 14th, the temperature did not exceed 102 at any time during the day. The left knee was nearly well, the right knee much improved, but both ankles were still tender to the touch; the urine was, as usual, normal. By this time the oedema of the face had entirely disappeared. 15th, the fever subsided and with it much of the pain, though the ankles were still swollen. She limped for a day or two, then rapidly regained her usual health. The wound had healed. Since then she has been perfectly well.

The unusual features of this case were: 1. The length of time elapsing between the injection of the antitoxin and the onset of anaphylactic symptoms, which was nine days. 2. The eruption, which was of a dual type, lasting four days. 3. The oedema of the face, lasting six days. 4. The joint infection, accompanied by fever, pain, swelling, prostration and delirium, lasting a week, making a total of twenty-seven days after injection. The average case of anaphylaxis starts in from a few hours to a day or two after the injection, hence the period of nine days makes this case of more than passing interest. Another condition was the oedema which put in its appearance promptly after the eruption had vanished. The oedema was peculiar in this respect, that although in the morning it was hardly discernible, in the afternoon the face was so puffed as to be startling in appearance; the eyelids being so oedematous that they were opened with difficulty. Then, to cap the climax, after all these symptoms were a thing of the past, the severe arthritis with its pain, fever, delirium and prostration supervened. Thus the series of symptoms started in nine days after the time of injection and lasted until the 27th.

The treatment employed was eliminative and symptomatic. The bowels and kidneys were kept active and the patient kept in bed when necessary, and the pain, pruritus and fever met by appropriate measures. The patient is *now* in good health and going to school.

Dr. J D. Thomas said that the symptoms exhibited by Dr. Smith's patient were very interesting. The milder forms of anaphylaxis are frequent; cases of the severity of the one reported are uncommon. Last summer, in consultation with another physician Dr. Thomas had seen a case of severe anaphylaxis. The

patient was a lady who had had an attack of facial erysipelas and had been treated by a physician in Pennsylvania who used injections of some serum ; she went to North Carolina, and having a recurrence of the erysipelas, the doctor there communicated with the Pennsylvania physician and continued the injections of the same serum. On coming to this city she was seized with an extensive urticaria which became extremely painful and prostrating. Dr. Thomas had just read an article suggesting the use of adrenalin chloride in such cases. An injection of this drug was followed by immediate relief of the cutaneous symptoms, but after a few hours severe joint pains made their appearance. The adrenalin injections were given for several days. All the symptoms finally cleared up.

Dr. Roy hardly agreed with Dr. Smith in the statement that it is unusual for anaphylactic symptoms to occur as late as they did in his case. If we accept the theory of the production of anaphylaxis now commonly held we can easily understand why the symptoms would naturally appear late. Sensitization depends upon the slow production of a ferment specialized for the splitting up of foreign protein ; symptoms do not appear until enough of this ferment has been produced to cause a rapid splitting of protein with the liberation of large quantities of the poisonous protein radicle. In the treatment of this poisoning the administration of barium chloride will more certainly and quickly relieve the symptoms than will the use of adrenalin. The protein poison acts especially upon the vaso-motor system, which accounts for the beneficial effects of adrenalin in anaphylaxis.

Dr. D. G. Smith thanked the speakers for their remarks. The theoretical considerations advanced by both were rather borne out by the analogies to be found in the etiology of hay fever and the beneficial effects to be got from adrenalin in the treatment of that disease.

EXPERIENCE AT VERA CRUZ.*

By George Tully Vaughan, M. D.,

Washington, D. C.

When, April 21st, the report reached Washington that the landing of our naval forces at Vera Cruz had been resisted by the Mexicans and that a battle had begun, I felt it my duty as an officer in the Reserve Corps to offer my services ; so the next morning I called on Surgeon General Braisted for that purpose. He asked me how soon I could start for Vera Cruz. I replied that I could start in a few hours. He said he thought that I would have to catch a vessel leaving Norfolk the next morning. I said that I would

* Dr. Vaughan was on the program for this statement for November 25, but was unable to attend the meeting.

catch it. Subsequently it was decided that I should go on the *Morro Castle* which was to leave Philadelphia the next day at 4 P. M. Having hurriedly made my arrangements, I left Washington early on the morning of the 23d and reported on board the *Morro Castle* about 2 P. M. the same day with the following orders: "Proceed immediately to Philadelphia, Pa., and report to the Commandant of the Navy Yard for passage on the *Morro Castle* to Vera Cruz. On arriving at Vera Cruz you will report to the Commander-in-Chief, Atlantic Fleet, for duty as operating surgeon in the City of Vera Cruz or with the Atlantic Fleet, as the Commander-in-Chief may direct. (Signed) Victor Blue, Acting Secretary."

The *Morro Castle* was taking to the scene of disturbance a regiment of Marines under command of Col. Franklin J. Moses, with several officers for duty on the ships of the fleet. For two of the officers of this regiment, Colonel Moses and Captain Owen, this was their last expedition, as both died at Vera Cruz, one of pneumonia and the other of dysentery. The trip was smooth, but everybody was anxious for news, which we occasionally received by wireless, one item being the destruction by fire of the Western High School in this city, and various rumors as to the progress of the affair at Vera Cruz. Many joking remarks were made about the probability of an attack on our ship by one of the Mexican gunboats while on our way, but on arriving at Key West it became evident that in some quarters this menace from the Mexican gunboats was taken seriously, as we heard of the offer of the Cuban Government to convoy us, which offer was courteously declined, no doubt with proper expressions of appreciation; and two of our own torpedo-boat destroyers fell in with us and accompanied us during the remainder of the trip, which was finished without notable incident. We reached Vera Cruz about 3 A. M. the 29th, in a rainstorm and considerable heat. When daylight came and the clouds lifted we had a splendid view of our fleet, thirty odd ships of war including seventeen magnificent battleships, besides the war vessels representing foreign Governments, the English *Suffolk*, the French *Condè*, the German *Dresden*, the Spanish *Carlos XIII* and the Dutch *K*. The English vessels were commanded by Rear Admiral Sir Christopher Craddock, who went down with his flagship, the *Good Hope*, when his squadron was destroyed by the German squadron, *Scharnhorst*, *Gneisenau*, *Nürnberg*, *Leipzig* and *Dresden*, under Vice Admiral Graf von Spee, about November 1, off the coast of Chile, and von Spee in turn went down with his flagship, the *Scharnhorst*, when his fleet was destroyed about December 8 between the Straits of Magellan and the Falkland Islands, by the squadron under the command of Vice Admiral Sturdee.

As soon as possible on arrival at Vera Cruz I reported to the

Commander-in-Chief, Rear Admiral Badger, on board his flagship, *Arkansas*, and was assigned to duty with the First Brigade of Marines on shore, in command of the Field Hospital, which had not yet been organized. As a result of two days of fighting, April 21 and 22, our losses were 17 killed and 63 wounded, and that of the Mexicans, as estimated by Surgeon M. S. Elliott, was between 152 and 175 killed and 250 wounded. The wounded Mexicans were for the first few days treated by Navy surgeons, but as soon as the Mexican surgeons returned they were naturally given charge of their countrymen. I saw quite a number of these wounded in hospitals a week after they were wounded. One poor fellow had a bullet wound through his upper jaw with extensive comminution, and another was sitting up in bed with a gangrenous foot and leg, evidently from a gunshot wound of the femoral vessels.

The medical officers of the Navy have done excellent work in caring for the wounded during and after the fight in which many of them served on the firing line and during the days that followed in getting the men quartered and cared for in the most sanitary way. After the blue jackets returned to their ships the naval forces on shore consisted of a little over 3,000 marines, under command for a short time of Colonel Mahoney, and then during the rest of the time of Colonel L. W. T. Waller, U. S. M. C., an able and distinguished soldier with the experience of numerous campaigns in various parts of the world. In a short time a brigade of the Army was added to Colonel Waller's brigade of Marines, and the division thus created was placed under the command of Brigadier General Funston, U. S. A. The water works at El Téjar on the Jamapa River, nine miles from town, consisting of an excellent filtration plant, settling basins and pumping station, the chief source of water supply to the city, was guarded by a battalion of Marines under Major Russell, U. S. M. C. This was our most distant and therefore most exposed station, against which demonstrations were occasionally made, but they amounted to nothing serious.

At the time of my arrival, and for some time afterwards, the impression was general that we were to march on to Mexico City. Therefore arrangements were made so that we could pull up on short notice to take the line of march or the field. Surgeon D. N. Carpenter, U. S. Navy, an accomplished officer and skillful physician and surgeon, was brigade surgeon of the marine brigade, and there were surgeons for each of the three regiments in the brigade; I was placed in command of the field hospital and as chief operating surgeon. In organizing the field hospital the brigade surgeon was careful to limit the supplies and equipment to the smallest quantity and of the simplest character consistent with efficiency, in order to have the organization as mobile as possible. While awaiting orders to advance, the field

hospital was used as a brigade hospital, receiving the sick and wounded from the brigade, who were too ill to be treated at the regimental dispensaries. A school building one story high, near the edge of the town, and containing four long, wide rooms communicating with one another on the sides, and having a water supply and toilet room at the rear end of each room, was selected. Two of these rooms were fitted up with cots; one was used as the medical ward, the other as the surgical. Another room was used as the mess room for the apprentices of the hospital corps and such patients as were able to go to the table, while the front of the same room was used for patients when the wards could no longer accommodate them, and the toilet room outside the rear end was closed and a small kitchen was constructed.

The capacity of the hospital was 40 to 45 beds. Mosquito bars were provided for all cots; doors and windows were screened against flies, and electric fans were used in the wards day and night on account of the heat. One room was divided into two by means of a tarpaulin across the middle which could be rolled up or let down as desired, the front being used as the surgeon's office and the rear for an operating and sterilizing room. For surgical operations the material was sterilized in a small sterilizer and iodine and alcohol chiefly were used in the preparation of patients. The hospital corps men consisted of two stewards and thirteen apprentices. With this rather primitive outfit, 66 major operations were performed by Dr. Carpenter and myself, besides a number of minor ones, including appendectomy, herniotomy, thoracotomy, cholecystectomy, etc., without a death, and with as good results as are obtained in thoroughly-equipped hospitals. Ether for general and cocain for local anesthesia were used, and there was no difficulty in the administration of ether by the drop method, in spite of the high temperature. A few cases of gunshot wounds were treated. In one case a marine was accidentally wounded at target practice, the range being probably over 500 yards; the bullet struck the left shoulder about three inches posterior to the acromion process and emerged a little beyond the acromial tip over the origin of the deltoid. The wound of entrance was quite small, about the diameter of the missile, while the wound of exit was quite large, the skin being retracted and lacerated to fully three inches in diameter. Whether this was the explosive action of the bullet or whether it was the change of the missile from a longitudinal to a transverse axis in its passage through the tissues, perhaps due to touching the bone with its tip, cannot be decided.

After two and a half months' service with the brigade of Marines I was convinced that our forces would not be sent into the interior and requested to be ordered back to the fleet, preliminary to my relief from active duty, and return home. I was directed to report July 14 to the admiral on the *Wyoming*, which was then the flagship, for duty in the fleet.

A few words more before leaving Vera Cruz. The principal diseases from which the men suffered were venereal, malaria and dysentery, the first being the cause of from 25 to 40 per cent. of the total sick. Malarial fever reached its greatest height in August. The dysentery was of the bacillary type, only four cases being amebic, and two of these contracted their infection elsewhere (brigade surgeon's report).

Vera Cruz is an interesting little city with a population variously estimated at from 30,000 to 60,000, situated on the Gulf of Mexico, with the sandhills behind, and almost exactly on the 19th parallel of north latitude. Westward, some 30 to 40 miles distant, rises in perennial beauty the snow-capped peak of Orizaba. The principal streets are well paved with asphalt; there is a good water supply and sewage system, and under normal conditions I am told that the city is quite clean. Children scantily, and therefore comfortably, clad are quite numerous; so are dogs, buzzards and great-tailed grackles. To me the buzzard was a very interesting bird, and I had never before had sufficently near acquaintance to appreciate some of his good points. He is a good scavenger, removing all the dead bodies of dogs, cats and other animals or fragments of them which can be found in the streets, and whenever the garbage cart came around I often saw from six to a dozen of these birds sitting on the cart, searching the contents for alimentary prizes. A very graceful bird soaring in the sky, when he walks or hops on the ground he appears awkward in the extreme, as if one leg was longer than the other. The grackle seems also to be somewhat of a scavenger, but he is a very handsome, glossy, black bird, with long tail and beak, noisy and ubiquitous.

The old castles or forts are very interesting, namely, Santiago and San Juan de Ulloa. The latter is of most importance, built about 300 years ago, on an island on the right of the entrance into the breakwater, with moat, and many cells that remind one of the Doges' old prison in Venice, only they are worse, being small, poorly supplied with light and air, and wet at all times with water dripping from the walls. This building was used as a prison and also for the instruction of naval cadets. The cells were in an exceedingly filthy condition. It was said that the average life of a person confined in one of these cells was seven years.

South of the entrance to the city is Sacrificios Island, so called, the story goes, because here the people, before the conquest of Cortez, offered up their human sacrifices.

Bull fights were still permitted on my arrival at Vera Cruz. The bulls were rather small and not at all belligerent until they were goaded and worried into some degree of resentment; even then they often tried to escape by leaping over the fence which enclosed the arena. Sometimes the bull would hang on the fence,

part on each side, and would be pulled back. If he succeeded in getting over the fence he found another fence encircling the first with a space between, along which he ran until he came to an open gate or door, through which he rushed to find himself back in the arena, from which he thought he had escaped. When the time comes to dispatch the bull some courage and considerable skill are required to do it neatly. The object is to thrust the sword into the back of the bull just behind the shoulder, or rather to let the bull impale himself on the sword as he dashes forward, so that the blade passes between the ribs and into the chest, where it opens the heart or some one or more of the great vessels. When the blade enters properly, blood immediately gushes from the animal's nose and mouth, and he reels and falls. Several times I saw an inexperienced man fail to enter the chest, the blade of the sword simply slipping between shoulder blade and chest, the point projecting through the skin below, making a comparatively slight wound.

There were many interesting things on the *Wyoming* as on any other dreadnaught, such as the batteries of great guns and their control, the storing and handling of ammunition, the heat in the fireroom, 138 F. when the ship is at rest, and 148 when under way; the manoeuvers in the sham battles of the fleet, the torpedo practice, and many other matters of absorbing interest, but it would prolong this story too much to tell of them. I finally received orders to come home, and set out August 8 on board the *Texas*, which with the *Louisiana*, had been ordered to New York. The *Texas* is a super-dreadnaught, and the most powerful man-of-war in the Navy, with the exception of her twin, the *New York*, the battery consisting of ten 14-inch guns and twenty 5-inch guns, and other things on the same gigantic scale. Three days out from Vera Cruz, near Key West, we received orders by wireless to proceed to Guantanamo, so our course was changed for the south. The second day after this change of course we received a wireless from the *Louisiana*, which we had not seen for several days, that she was in distress and needed assistance, so our course was again slightly changed, and, after a run of about eight hours, we reached the *Louisiana*, limping along the northern coast of Cuba, a little west of Nipe Bay, with a disabled tail shaft. Next day both ships entered Nipe Bay and the tail shaft was repaired by splinting it, suggesting a gigantic operation for fracture, so that the ship could proceed at reduced speed on her way home, the *Texas* accompanying. This accident to the *Louisiana* prevented our going to Guantanamo, as we were ordered to convoy the disabled vessel to Hampton Roads for repairs. We reached Hampton Roads, five days from Nipe Bay, under the most favorable weather.

EXPERIENCES WITH THE MARINE EXPEDITIONARY FORCE IN MEXICO.*

By R. M. Little, Assistant Surgeon, Medical Reserve Corps, United States Navy.

The following article has been prepared with the idea of presenting to my fellow members of the Medical Reserve Corps of the Navy a practical idea of what the receipt of orders detailing to active service involves, and some few of the experiences noted by a practitioner suddenly called into the unfamiliar surroundings of a military life.

On the afternoon of April 21, 1914, I received a telephone message requesting me to come to the Bureau of Medicine and Surgery of the Navy Department. Here I was informed that a marine expeditionary force was being organized, and was asked if I could be ready to join it at once. I had made a request for active service some time before. On April 22 I received telegraphic orders: "Proceed immediately Philadelphia, Pa.; report commanding officer, and when directed by him, to commanding officer marine expeditionary force sailing on board the *Morro Castle* for duty with that force. (Signed) Victor Blue." According to United States Navy Regulations, if orders read "immediately" an officer shall leave within 12 hours of their receipt. I left Washington at 3, arriving at Philadelphia at 6. I telephoned the commandant of the Philadelphia Navy Yard, and was informed that I could report the next morning at 10, and that I might go aboard the *Morro Castle* that night. I had very little time to be advised about my personal equipment, and carried a number of useless things and left out some of the necessaries.

I found the following articles sufficient: One suit civilian clothes, one suit uniform (blue), two suits uniform (white), including white cap and white shoes; three pairs khaki riding breeches, two khaki blouses, three flannel shirts, one pair tan shoes, one pair puttes, half dozen suits underwear and socks, a campaign hat, hat cord, bronze buttons and corps device, bedding roll, blankets, pillow and clothing roll.[1]

The Third Regiment was composed of barrack detachments and prison guards from all the stations along the Atlantic coast from Portsmouth, N. H., to Port Royal, S. C. They began to arrive in the morning of April 23. The officers were assigned their rooms on the *Morro Castle* by the regimental quartermaster.

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[1] Naval officers and men serving with an expeditionary force of marines may wear the field uniform prescribed for officers and enlisted men of the Marine Corps, respectively, substituting naval insignia for those of the Marine Corps. (Art. 55 (b); Uniform Regulations, 1913.) The following allowance of baggage is prescribed for officers ordered on expeditionary duty with marines: All officers: Bedding and clothing roll (mounted officers, in addition, horse equipment); field officers, 2 steamer trunks. No trunk shall be taken whose cubic contents is more than 5 feet. Officers will provide themselves with the standard Army trunk, dimensions 31 by 17 by 14 inches. (Headquarters U. S. Marine Corps, Aug. 9, 1913.)

I reported to the commandant of the navy yard, had my orders endorsed, then went to the paymaster and drew my mileage. Returning to the ship I reported to the regimental surgeon and assisted in supervising the loading of the medical stores. After loading all the stores the men embarked and the ship left the dock at 4.30 P. M. I thought this was rapid work to assemble a regiment of 850 men that was so scattered and load the ship with stores for three months in so short a time.

As soon as we were under way ship routine was established, sick call being at 9 o'clock. It was taken alternately by the battalion medical officers. We had few cases of seasickness, as the weather was fine. We treated a number of cases of minor injuries incurred while loading stores. One case of acute appendicitis we put ashore at Key West. Drills and instructions were given every day. There was officers' school each morning for the study of Spanish. The regimental surgeon gave the company officers instructions in first aid and camp sanitation. After we were out two days the men were all inspected. All not having a recent successful vaccination were vaccinated. A record of cases not having had typhoid prophylaxis was made. The latter was given when we went into camp.

We arrived at Vera Cruz April 28, about the beginning of the rainy season. The next morning I received the following communication: "Subject: Orders. 1. You will report to Maj. John H. Russell, Marine Corps, commanding the Second Battalion, at once; for duty on detached service with the battalion under his command. 2. You will be accompanied by a hospital steward and three apprentices who will report to you for duty. By order of Col. Moses." The Second Battalion, consisting of the Twenty-second and Twenty-third Companies, disembarked, entrained with ammunition and store, and went into camp at El Tejar. Later we were joined by the First Company of the Artillery Battalion and the Twenty-first Company of the Second Battalion, making a total of 500 officers and men.

El Tejar is situated on the Jamapa River, 9 miles from Vera Cruz. There is a narrow-gage railway connecting it with the city. The pumping station and filtration plant for the water supply are located here. Owing to the nature of the duty in guarding the water supply, the camp was selected to be central as well as sanitary. The country is open and level, the soil sandy and well drained. We received our water from mains supplying the city. Before the rainy season was well advanced we had a fine bathing beach in the river below the intake for the pumping station. The water was clear, the course rapid, and the bottom covered with fine, black sand; as the season advanced the water became muddy and the current too rapid for safe bathing. We had shower baths in the camp.

The galleys were located near the water outlets and were kept

well drained. As they were not floored, the ground was sprinkled with crude oil to keep down the dust and prevent the presence of flies. Later, when material was available, they were screened. All refuse from the galleys was buried at some distance from camp. Afterwards permission was given by the brigade sanitary inspector to dump this waste in the river below the ford. This work was done by a detail in charge of the police sergeant. Incinerators were not used owing to the lack of wood. Latrines were dug 18 feet long, 5 feet deep and 18 inches wide, one for each company. They were located close to camp so that it was not necessary to use night cans. By burning them out daily with crude oil and hay there was no annoyance from flies or odor. This was done by detail under the supervision of a hospital apprentice. Later, when we could get the lumber, in order to establish an absolutely sanitary condition, box covers were made. The frames were made of 2 by 4 inch, covered by boards 1 by 6 inch. The top was hinged so that it could be opened when the trench was burned out. The seats were cut in the top, 18 inches apart, and had close-fitting covers that were made to fall into place when not in use.

No horses were permitted in camp. The manure from the corral and picket lines was carted a mile from camp.

There was difficulty in keeping dogs out of camp, but this should be done, as there is always a risk of rabies.

Owing to the presence of smallpox in the vicinity, everyone in camp was vaccinated, a large percentage being successful. The natives having this disease were sent to the lazaretto and all others vaccinated. Of the 15 men given the typhoid prophylaxis only one showed any reaction. He had a temperature of 102° for 24 hours. He had had typhoid fever three years before, and the vaccine was given at his request. The men were not permitted to carry food to their tents, nor did we allow the use of native milk, fruit without skins, or uncooked vegetables. Cots and blankets were aired once a week. Tents were struck once a month.

We had a few flies or mosquitoes in camp, but the mosquitoes and ticks were very troublesome on the outposts. At the Marino Bridge, about two miles from camp, they were very bad. The men experienced most relief from the use of the oil of citronella. In camp the men slept under nets. There was a daily sanitary inspection of the camp. The men were inspected once a week. I had a hospital steward and five apprentices. Only one, an apprentice, had been in camp before. One apprentice was detailed with the outpost at the Marino Bridge, a detachment of 20 men, who were relieved every five days. All other outposts were relieved every 24 hours. Two apprentices were detailed to supervise the burning of the latrines and the oiling of any pools that we were unable to drain. At a call to quarters the marines went

to the trenches; one apprentice was with each company. The hospital steward remained with me at the dressing station. Apprentices were given daily instruction for one hour in first-aid care and transportation of wounded and bandaging. We had two hospital tents, one used by the apprentices, the other we used as sick bay, and was occupied by the hospital steward. We had company outfits, medical and surgical, and drew on the regimental store for such medicines and dressings as we needed for daily use. We had a complete microscopical outfit. We had a few cases of malaria, the majority giving a history of a previous attack. It was a mild type and yielded readily to treatment. There was one case of measles. The patient with all his gear was isolated in a tent. Another tent was given the apprentice detailed to care for him. The patient made a good recovery, but his convalescence was slow. His tent mates were quarantined for 15 days. During our stay in camp our complement averaged 441.

The sick rate was 0.5 per cent. Seven cases of venereal disease were admitted, making the ratio 18 plus per thousand. The low percentage of sick, considering the arduous duties of digging trenches, cutting trees, building defenses, etc., reflects credit on the officers and men in the care of themselves and the strict observation of the sanitary regulations.

Dr. A. B. Hooe said that so far as he had been informed there were only three Medical Reserve officers called to active service during the activities caused by the Mexican trouble, and all of these were members of the Medical Society of the District of Columbia. He thought we ought to congratulate ourselves on this record.

PERSISTENT GLYCOSURIA A SYMPTOM OF FUNCTIONAL LIVER FAILURE FROM FOCAL INFECTION.*

By Ernest F. King, M. D.,

Washington, D. C.

From an old volume I quote the following saying of Hippocrates:

"We ought to attend and observe what things they are that are evacuated by urine and stool, and what by the flesh, and whether the body declines in any other respect from nature." In carrying out this admonition of the prince of physicians, Thomas Willis, in 1674, noticed the sweet taste of a specimen of diabetic urine (diabetes then meaning simply polyuria), and despite the many studies of reported cases, of post-mortem findings and of

* Read before the Medical Society December 16, 1914.

the many, many animal experiments that have been made in the two hundred and forty years that have since elapsed, we are today as ignorant of the cause as was the discoverer. We have been told what happens after irritation of certain points in the brain, after the administration of certain drugs, after the extirpation of certain organs, and after the ligation of nearly every vessel in the digestive tract, but the "why" of the sugar remains unknown.

In the early days various organs were believed to be at fault, and Cowley, in 1784, and Bright and others, in 1833, traced the trouble to the pancreas.*

In 1849 Claude Bernard produced glycosuria by puncturing certain spots in the floor of the fourth ventricle, and his experiment formed the basis of the nervous theory with which the text books of the following years were filled. Even as late as 1885, Tyson, in Pepper's "System," while allowing other probable causes, gave much space to a description of the sugar centers and their connection with the sympathetic system. Bernard, however, came to the conclusion that the liver was the organ principally at fault. But, although at least 25 per cent. of glycosuric livers are enlarged, there is no liver lesion universally present with glycosuria, and in most diseases of the liver glycosuria is not a symptom.

In 1885 it was discovered by v. Mering that phloridzin, a glucoside derived from the root barks of various fruit trees, caused a glycosuria without hyperglycaemia. Zuntz injected phloridzin into one renal artery and sugar promptly appeared in the urine from the kidney of the same side, not appearing from the other kidney for a half hour. The kidney, it was concluded, caused glycosuria. But, again, no changes in that organ could be found that would account for the symptom.

In 1889 von Mering and Minkowski removed the pancreas from a dog and glycosuria followed, and like results were reported by many other experimenters, and although, as in puncture glycosuria, the sugar disappeared in a few days, and did not appear if the dog were fasting, and although sugar did not appear in the urine if a small portion of the pancreas were left, the medical world looked to the pancreas as the seat of all saccharine troubles, and when Opie, in 1900, described lesions in the islands of Langerhans the matter for many was definitely settled. But acute pancreatitis, with or without hemorrhage or necrosis, is not accompanied with glycosuria, and in chronic pancreatitis sugar is present in the urine in only a small proportion of cases, and there is no relation between the abnormal findings in the pancreas and the sugar in the urine.† Naunyn, up to 1896, found only one diseased pancreas in forty diabetics, and in the next ten years in

* Historical data from Lepine "Le Diabète Sucrè," Paris, 1909.
† Schmidt, *Munch. Med. Woch*, Aug. 4, 1914, p. 1739.

nine cases found only four sound ones. W. Hale White,* collected a series of 142 cases of disease of the pancreas, in only 19 of which was glycosuria present, warranting the inference that the pancreatic condition was a coincidence rather than a cause.

Continued investigation brought to light the internal secretions of the liver, pancreas, adrenals, thyroid, spleen and other glands of the body, and the latest, the Zuelzer theory, supported by van Noorden and the Vienna school, is that glycosuria "is dependent upon a disturbance of the correlation of the ductless glands." The thyroid, pituitary and suprarenals (chromaffin system) stimulate the mobilization of carbohydrates, and are known as the accelerator group, while the inhibition group (pancreas and parathyroids) works in the opposite direction. Under normal conditions the effect of the one group balances that of the other, but when this balance is disturbed the glycogen-storing power of the liver rises and falls as the one or the other group is in the ascendency. The action of the various hormones has been established by many observers, but we are still ignorant of the cause of the disturbance of balance.

We have been taught that carbohydrates are changed into maltose by the saliva, and that maltose becomes dextrose under the influence of the pancreatic and intestinal juices and the cells of the intestinal walls. A small portion of the dextrose in the body comes from proteins and probably some from fats. Part of the dextrose is taken up by the lacteals and enters the general circulation through the thoracic duct, but is so small that it may be neglected. The greater part is carried by the portal vein to the liver, where it loses a molecule of water and is stored up as glycogen until needed as muscle fuel, when it is given up as dextrose again.

All glycosurias, except those produced by phloridzin and some other poisons, are accompanied by hyperglycaemia. A temporary hyperglycaemia may result from the ingestion of excessive quantities of carbohydrates, in relation to the demand of the muscles, and individuals vary in their sugar-caring capacity. The only other way in which hyperglycaemia may be produced is by a diminution in the glycogen-forming and storing capacity of the liver.

Glycosuria, the appearance of grape sugar in the urine, is but a symptom of the failure of the sugar storehouse, the liver. Diabetes mellitus means now only a persistent glycosuria, and the term should be discarded on the ground that it is not accurately descriptive of the symptom and also that it conveys the false impression that it is the name of a disease entity.

I would divide all glycosurias into two classes: Ephemeral; with the subheads (*a*) alimentary, (*b*) traumatic, (*c*) toxic. Persistent; all toxemic.

* *Lancet*, March, 1903, p. 714

The purpose of this paper is to endeavor to show that the liver fails to store sugar as the result of the action of toxins produced by more or less distant bacterial infection. I am led to this opinion by a consideration of the following cases and facts.

Glycosuria has been reported as present in pyorrhoea, acute tonsillitis, parotitis, pneumonia, pulmonary tuberculosis, typhoid fever, scarlet fever, intestinal disorders, cystitis, prostatitis, skin diseases and other conditions in which bacterial infection is present.

In 1911 I made frequent urinary examinations for a man of fifty, finding on the average 2 per cent. of sugar. He showed no loss of weight, no polyuria, no thirst and no increase of appetite. The usual remedies were tried and careful diet ordered, but the sugar never disappeared. He also had a chronic abscess at the root of an upper tooth which his dentist was trying to save. Finally, the pain became so intense that the tooth was extracted. The sugar disappeared from his urine and has not reappeared.

In June, 1914, I gave a prostatic, who also had a mild cystitis, fifteen grains of hexamethylenamine *t. i. d.* His morning urine always contained sugar. On the fourth day after beginning the drug there was no sugar in the urine, though there was little change in the bladder condition. Early in September I again found sugar in his urine and repeated the medicine and again the sugar disappeared and is still absent, now three months.

On November 14 I ordered hexamethylenamine for a patient who had been turned down repeatedly for life insurance since 1909. On the above date there was 1 per cent. of sugar present. Four days later there was none, and I have found none in three specimens examined since that time.

One of the house physicians at Johns Hopkins Hospital recently told me of an outpatient with a liver extending two inches below the costal margin. He had a severe pyorrhoea and a dentist extracted all his teeth at one sitting. The liver promptly returned to normal size. I could not find out that glycosuria was present, but the case is of interest in this connection.

Dr. W. P. Carr,* some five years ago, reported to this Society an operation for gallstones. An accompanying glycosuria promptly cleared up and has not returned.

Dr. M. Brodsky, formerly of the faculty of the University of Kiev, but now a dentist of this city, told me of a dental student whose mouth is known to have been clean, who suddenly developed a severe pyorrhoea alveolaris. Sugar was found in the urine, and the condition of the gums was thought to be due to the glycosuric condition. I believe the pyorrhoea could have been shown to have been the cause, as both conditions cleared up in a short time.

* WASH. MED. ANNALS, IX, 1910, p. 25.

Dr. Brodsky at present has a pyorrhoea patient whose urine, examined by Dr. Eisenberg, shows the presence of levulose.

Eising[1] reports two cases in which sugar disappeared from the urine after prostatectomy, and quotes a like result after the removal of a fibroid tumor, and also after two other prostatectomies that were reported during the discussion of a paper by Joslin.[2]

v. Noorden[3] says, "I remember several cases of furunculosis and staphylococcus sepsis in which within a week a slight diabetes progressed to a severe glycosuria with marked acetonuria. When the infection terminated, the diabetes assumed again the milder form."

Dr. Frank Billings, at Atlantic City last June, read a paper on "Focal Infection," in the opening paragraph of which he says "In my opinion focal infection is very frequently related to local and general disease. Apparently it is an important factor in some systemic diseases heretofore unsuspected."[4]

Rosenow has found embolic bacterial masses in the terminal arteries of joint structures, heart valves, muscles and other tissues. In cholecystitis[5] he found various strains of streptococcus in the walls of the gallbladder, and two of these strains injected intravenously caused both cholecystitis and pancreatitis.

DaCosta and Beardsley[6] note that glycosurics as a rule have a subnormal opsonic index to streptococcus, staphylococcus and bacillus tuberculosis.

Dr. J. H. Selby reports to me the case of a man who for seventeen years had sugar in his urine. He also had acne and the sugar content of the urine varied with the acne condition. The acne finally was cured, the sugar clearing up at the same time.

Dr. I. H. Lamb reports to me the case of an aged woman with severe cystitis, sugar being found in the urine late in the disease.

Scattered through the comprehensive monograph of Naunyn[7] are reports of 130 cases of glycosuria in many of which pus processes were present, frequently tuberculosis pulmonalis. In case 70 there was a prostatic abscess with 11 per cent. of sugar in the urine. He also gives the post-mortem findings in a series of 49 cases; 34 of these had lesions of the lungs and pleurae, 3 lesions of the stomach and intestines, 1 ulcer of the rectum, 1 cystitis and pyelitis, and 1 arterio-sclerosis. In only 7 were no pus foci found and the pancreas was normal in nearly all the cases. Naunyn suggests that the good effect of the oatmeal cure may come from the bactericidal powers of some of the fermentation products peculiar to this food.

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[1] *Jour. A. M. A.*, April 18, 1914, p. 1224.
[2] *Jour. A. M. A.*, Sept. 12, 1912, p. 933.
[3] *New Aspects of Diabetes*, p. 151.
[4] *Jour. A. M. A.*, Sept. 12, 1914, p. 899.
[5] *Jour. A. M. A.*, Nov. 21, 1914, p. 1835.
[6] *Am. Jour. Med. Sci.*, Sept., 1908, p. 361.
[7] *Der Diabetes Melitus*, 1906.

Opie[1] produced cirrhosis of the liver by inoculation with the bacillus coli.

Colla[2] found that in anthrax, pneumonia, tetanus and diphtheria, glycogen disappears from the liver and the dextrose in the blood increases.

Funck[3] urges the treatment of the cause rather than the symptom of diabetes, and says, "It may be declared that the cause of diabetes is a gastritis or enteritis." Very recently[4] he repeats his plea and gives results in cases in which the intestinal tract was flushed by means of a duodenal tube. One of his reasons for doing this is that "it changes the flora of the intestine and the food supply of the bacteria."

Richartz[5] believes that catarrhal inflammation of the mucous membranes of the intestine causes transitory glycosuria.

Karl Strube[6] reports a series of cases of glycosuria cured by stomach lavage.

Many cures are reported following the free use of Carlsbad, Neuenahr and other cathartic mineral waters.

Diabetics have been reported cured after the use of emetics, purgatives, yeast, benzoic acid, permanganate of potash, sulphite of soda, sulphide of calcium, quinine, carbolic acid, peroxide of hydrogen, tincture of iodine, salicylic acid and the salicylates, creosote, arsenic and other drugs, all of which would tend, mechanically or chemically, to sterilize the digestive tract.

In two of the cases I report, hexamethylenamine caused the disappearance of sugar from the urine. The bactericidal action of this drug in these cases probably took place in the stomach. The studies of McGuigan and Hess, and of Hinman[7] show that this drug yields formaldehyde only in the presence of acids, and would therefore be of use only in the stomach and in acid urine. When hexamethylenamine is given in sufficient doses (15 grs. two or three times a day) Burnham's test detects formaldehyde in the urine of nearly every individual. Smith[8] examined 213 specimens of urine from 50 individuals, and in only one case did formaldehyde fail to appear. How hexamethylenamine gets by the acid stomach to be broken up in the urine remains to be seen.

As formaldehyde in solution is not excreted by the kidney[9] it would seem advisable to use the drug in this form for sterilizing the intestinal tract. Beginning with a solution of 1 to 5,000 and gradually increasing, the point of tolerance for every individual could be determined.

It is probable that opium and its derivatives have been used more often than any other drugs in the treatment of glycosuria.

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[1] *Trans. Assoc. Amer. Phys.*, XXV, 1910, p. 140.
[2] *Arch. Ital. de Biol.*, XXVI, p. 120.
[3] *Munch. Med. Woch.*, June 7, 1910, p. 1224.
[4] *Arch. f. Verdauungs-Krankheiten*, Aug. 10, 1914, Vol. XX, p. 284.
[5] *Zentralblatt f. In. Med.*, 1910, p. 321.
[6] *Munch. Med. Woch*, June, 1910, p. 1221.
[7] *Arch. Int. Med.*, Vol. XIII, pp. 842–853.
[8] *Trans. Amer. Urol. Assoc.*, 1913, p. 239.
[9] Burnham, *Trans. Amer. Urol. Assoc.*, 1912, p. 286.

In the endeavor to explain its favorable action from the view point of the theory put forward in this paper, I asked many questions, and obtained from Dr. Kinyoun the suggestion that as, *in vitro*, salvarsan has no effect on the spirochete, nor quinine on the plasmodium malariae, nor atoxyl on the germ of sleeping sickness, so opium, which is ineffective in a culture, by combining with some substance in the body may produce a compound that will destroy the ordinary flora of the intestines.

Of late years the buttermilk cure has been very popular, the idea being to supplant the usual flora of the intestines with a pure culture of the lactic acid bacillus.

The so-called infectious glycosuria, or diabetes conjugalis, suggested by Schneider in 1890, is of interest in this connection. Senator[1] says that from 1 to 1.8 per cent. of all diabetics fall in this class. He reports a laundress of 62 who developed the disease after washing, for a period of six months, the clothing of a man and his granddaughter, both of whom were diabetic. A gouty man, whose mother died of diabetes, developed the disease himself, in consequence of grief, it was said. Six months later, his cook, age 60, who washed his handkerchiefs, and a sewing woman who had worked in his home for ten years, were found to have the same trouble. A diabetic lost his first wife from the same disease, remarried, and the new wife later showed sugar in her urine.

Naunyn reported the case of a young woman who developed diabetes after a visit to a married couple, both diabetics.

Senator's conclusion is that the infection may take place through sexual congress, kissing or the handling of clothing soiled by urine, faeces, saliva, or the secretions of the nose and air passages. As in most of the cases reported the infection came from one of the opposite sex, perhaps all but one of these methods may be disregarded.

About one-fifth of all diabetics are said to have inherited the disease, but it is probable that only a good soil for the trouble is inherited, and that the infection comes through eating the same foods, and other circumstances of life that would produce like bacterial invasions.

If the urine were to be examined in every case in which pus foci were present I believe sugar would be frequently found. Pyorrhoea seems to be a more or less common forerunner of glycosuria, but dentists do not examine urine. Others also are remiss in this particular.

If there be present no circumscribed pus focus as in pyorrhoea, acute tonsillitis, cystitis and the like, the flora of the intestines furnishes an inexhaustible supply of bacteria, so extensive indeed that the wonder is that anyone escapes some form of poisoning. Strasburger[2] estimates that 128 billion of micro-parasites are

[1] *Berlin Med. Woch.*, Jan. 27, 1908, p. 133.
[2] *Die Feces des Menschen*, Berlin, 1904, p. 282.

eliminated daily in the feces of an adult, and Cohendy states that two-thirds of the feces is made up of bacteria, dead or alive.

That all are not afflicted with glycosuria may be explained in various ways. As a lowered vitality from surgical or nervous shock favors the occurrence of this symptom, so a high degree of vitality would tend to prevent it. There may be a different susceptibility to toxins in different individuals, or there may be a difference in the quantity of toxins present or in the particular bacteria involved. Arany[1] suggests an unknown bacterium and says, "It is likely that researches will sooner or later establish the bacterial nature of the disease."

When a glycosuria disappears it is only until such time as a like bacterial growth recurs.

Most of the material that I have collected has appeared since the publication of Arany's surmise, in fact, much of it since the first draft of this paper was prepared. I believe that further animal experiments will determine the particular toxins that interfere with the storing capacity of the liver, and that the case will be proven by producing glycosuria by the injection of these toxins.

Ephemeral glycosuria does not call for treatment, as it is generally slight, and disappears in from a few hours to a few days.

Persistent glycosuria calls for the removal of the cause by surgical interference, stomach lavage, flushing out the intestines by duodenal tube or colon irrigation, the administration of intestinal antiseptics or the use of vaccines. Diet is an adjuvant which enables the liver, through rest, to return to normal, where it may be kept by the removal of the bacterial poison.

In conclusion, permit me to assure you that I have fixed in mind that Futcher says in regard to the subject under discussion, "It is unwise to accept any new theory," but I also recall that Celsus said, nearly 2,000 years ago, "The medicinal art does scarce admit of any lasting precepts."

Dr. Roy said that the paper was very interesting and very instructive. While the contentions advanced may not prove to be correct, the paper at least gives much food for thought upon this important subject. One of the interesting peculiarities of diabetes is the liability of Jews to the disease; are members of this race peculiarly liable to infections capable of giving rise to toxic glycosuria in accordance with Dr. King's ideas? As regards the influence of the liver on the causation of diabetes, it is a fact that if for any cause the bile gains entrance to the pancreatic duct it will set up a pancreatitis. Dr. Roy had risen particularly to express his thanks for the paper.

Dr. Nichols said that the paper was very suggestive and showed that glycosuria might be due to local infection or toxemia. But

[1] *Med. Press. and Circ.*, Feb. 5, 1908, p. 148.

to prove that diabetes mellitus is due to a toxic condition would require a very exhaustive study, covering many cases of focal infection as well as many cases of diabetes mellitus. If all cases of focal infection were examined as to this point, glycosuria would probably be found only in a minority of cases, and *vice versa*. It is true that infections are frequent in diabetes, but this is usually a result rather than a cause. The general consensus of opinion is that no one organ can be blamed for diabetes. One school contends that the disease is due to excessive sugar formation in the body. Another school holds that it is a sugar retention due to defective ability to utilize or metabolize the sugar of the food supply. We are in no position to ascribe the whole disorder to liver defect.

Dr. King said with reference to the prevalence of diabetes among the Jews that Arani holds that Jews are no more predisposed to this disease than are other races. The idea of many of the Jews themselves is that so many of them live sedentary lives and are good eaters, at the same time that a breakdown in metabolism results. Dr. King did not expect Dr. Nichols to depart from the accepted ideas with regard to diabetes; the fact remains that in all the cases quoted, glycosuria followed some infectious process with pus formation, or the two conditions were combined, with no data to show which arose first. If in these cases a disappearance of glycosuria followed directly upon the cure of the focal infection, there would certainly seem to be some connection between the two processes.

In Memoriam

DR. WILLIAM FRANCIS BYRNS.

Your Committee submit the following resolutions:

WHEREAS, We have learned with sorrow of the death of our fellow member, Dr. Wm. Francis Byrns, September 18, 1914, therefore, be it

Resolved, That the Medical Society of the District of Columbia records our expression of regret at the loss of so well qualified and worthy a physician.

Resolved, That we deeply sympathize with the bereaved family in their loss.

Resolved, That these resolutions be made a part of the records of the said Society, and that a copy thereof be forwarded to the family.*

(Signed) LLEWELLYN ELIOT,
EDWIN L. MORGAN.

* Resolutions adopted by the Society November 18, 1914.

Dr. William Francis Byrns was born in Bolton, Mass., August 6, 1847.

His early education was received at the public schools. He afterwards entered Harvard College, but did not complete his course. The degree of A. B. was conferred upon him in 1868, and that of A. M. in 1890, by Holy Cross College, Worcester, Mass.

Dr. Byrns came to Washington and entered the medical department of Georgetown College, from which he was graduated in 1873. Shortly after his graduation he went to Manchester, N. H., where he practiced medicine until 1878, when he returned to Washington, where he practiced until the time of his death.

Dr. Byrns was a member of the Medical Association of the District of Columbia; of the American Medical Association. In 1882 he became a member of the Medical Society of the District of Columbia.

For some years he taught Latin and English at Georgetown College.

Dr. Byrns was a modest, unassuming man; his loyalty to his friends was of the staunchest type. We studied medicine together, and the friendship of those days always continued. He was a close student, and his genial manner made him "Bill" Byrns to his intimates.

DR. GEORGE W. BOYD.

Dr. George W. Boyd was born in Washington, D. C., November 18, 1859, and died at his home, 121 Second St., N. E., November 21, 1914, having just attained the age of fifty-five years.

He was educated in the public schools of Washington, and graduated from the National College of Pharmacy of this city in June, 1880. Later he entered the College of Physicians and Surgeons at Baltimore, Md., receiving his degree from that institution in April, 1895. He at once entered upon the practice of his chosen profession, which he actively continued up to the time of his last illness.

Dr. Boyd was recognized as one of the leaders of the profession in the east section of the city and had established a very lucrative and extensive practice. He was noted for his acts of charity and kindly consideration for the indigent.

Had Dr. Boyd lived medical literature would have been enriched by a valuable contribution along scientific lines upon which he was busily engaged at the time of his death.

He was of a retiring, unassuming nature and rarely took part in the discussions before the Medical Society, but his interest in the same was manifested by his regular attendance at the weekly meetings.

Your committee would, therefore, offer the following resolutions: *

Be it resolved, That in the death of Dr. George W. Boyd this Society has lost a valued, honored and zealous member, and his colleagues a staunch, ethical and willing co-worker;

And be it further resolved, That a copy of this modest tribute to his worth and expression of sympathy and regret of this body be sent to his family.

(Signed) J. S. Arnold, M. D.,
Edward Warren Burch, M. D.,
Geo. J. Lochboehler.

PROCEEDINGS OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Stated Meeting, Wednesday, November 4, 1914.—Vice President Holden presided; about 110 members present.

The Corresponding Secretary was authorized to invite the following physicans to address the Society: Walter M. Brickner, Editor *Journal of Surgery*, and Charles Ball, St. Paul, Minn.

The Treasurer reported for October, receipts, $336.00; disbursements, $50.00.

The following applications for membership were received: Robert B. Bacon, College Physicians and Surgeons, Baltimore, 1893; Samuel L. Battles, G. W. University, 1906; Augustus C. Gray, same, 1912; Charles B. Healy, Georgetown University, 1908; Ralph M. LeComte, same, 1910; Patrick S. Madigan, same, 1912; Thomas Miller, Jr., G. W. University, 1914; Lester Neuman, Georgetown University, 1913; Francis J. Ready, same, 1913.

Dr. G. Wythe Cook, from the Executive Committee, made report with recommendations that the staffs of the hospitals and dispensaries in the city be informed that the privileges of the free clinics are abused, and their attention be invited to article 8, sections 1 and 2 of the by-laws, with request that the provisions of these sections be enforced.

2. That Dr. A. J. Potter be advised of this recommendation, and his attention also be called to the fact that the present regulations of the Board of Medical Supervisors cover the matter of licensing of midwives, referred to by him.

3. That the attention of the Board of Medical Supervisors be invited to the advisability of considering the revocation of the license of Dr. T. J. Kemp to practice medicine.

* Adopted by the Medical Society December 9, 1914.

4. That the American Society for the Control of Cancer be informed that no work of the nature referred to in their letter is at present being conducted under the auspices of this Society, but that the Society would be glad to coöperate.

5. That the Treasurer return the fee for Society dues to Dr. T. F. Wickliffe.

6. That in view of the low state of the treasury of the Society it is inadvisable at present to increase the salary of any officer of the Society.

7. That the annual dues be raised from four to five dollars, and the Constitution be amended to that effect.

8. That the following letter be sent to the Attorney General of the United States:

"*Resolved*, 1st, that in the opinion of the Medical Society of the District of Columbia the article entitled, 'What fools these mortals be,' by Dr. H. O. Hyatt, of Kinston, N. C., published in the *Southern California Practitioner* of March, 1914, is not 'obscene, lewd and lascivious,' as charged in the indictment against the editor of the said journal;

"2d. That if medical books and journals are forbidden to publish matters that might seem unsuitable for the daily newspapers, there would be an end to medical education;

"3d. That this Society recommends that the Attorney General of the United States be urged to discontinue the proceedings against the editor of the journal."

The recommendations were approved.

The following applicants were elected to membership: For active membership, William Brown Carr, G. W. University, 1907; P. Edward Larkin, Georgetown University, 1908; Boyd Richard Read, G. W. University, 1912; Davenport White, College of Physicians and Surgeons, N. Y. City, 1905.

For associate membership: Hugh McCormick Smith, U. S. Commissioner of Fisheries; Edward Melville Talbott, Captain M. C., U. S. A.; William C. Braisted, Surgeon General, U. S. Navy.

The following memorial committees were appointed:

For Dr. Valentine McNally: Drs. Vincent, Wall and J. D. Thomas.

For Dr. Wm. F. Byrns: Drs. L. Eliot, E. L. Morgan and Ober.

The following amendment to the Constitution was adopted: Article V, section 4, "No application for membership that is rejected or withdrawn shall be renewed until after two years from the time of its rejection or withdrawal."

Dr. G. Wythe Cook, as delegate to the A. M. A., reported that he attended the meeting of the House of Delegates at the Atlantic City session, 1914, and represented the sentiment of the Society in regard to the by-law of the Association having to do with the

jurisdiction of the Judicial Council of the A. M. A.; the matter was not yet settled. He had been appointed chairman of the Committee on Rules and Order of Business.

A letter from the Secretary of the A. M. A., in regard to the appellate power of the Judicial Council, was referred to the Executive Committee.

Dr. D. G. Smith reported a case of Anaphylaxis with unusual features. Discussed by Drs. J. D. Thomas, Roy and Smith. See page 18.

Dr. E. F. King reported a case of Myiasis larvae and showed a specimen. Discussed by Drs. L. O. Howard, O'Malley, Hagner, R. A. Hooe, W. P. Carr and King. See page 15.

Dr. Selby showed x-ray plates and a photograph, from the case of urinary calculus reported by Dr. L. Eliot October 7th, and stated that he failed to find evidence of the presence of bone. Discussed by Dr. W. P. Carr. See page 361.

Dr. J. R. Verbrycke read a paper, "Radiographic gastro-intestinal diagnosis; a note of warning," and showed x-ray plates. Discussed by Drs. Groover and Selby. See page 11.

Wednesday, November 11.—Dr. Holden presided; about 125 members present.

The resignations of Drs. M. R. Edmunds and W. A. Wickline were accepted.

A letter from Dr. N. P. Colwell, Secretary of the Council on Medical Education, A. M. A., asking the endorsement by the Society of a committee on standardization of hospitals, was referred to the Executive Committee.

The Society gave a rising vote of thanks to Dr. Franzoni, expressing its confidence in him and appreciation of his faithful and exact conduct of the office of Treasurer for so many years.

Dr. Adolph Juettner, of Cincinnati, addressed the Society on "Beginnings of Medicine in the Middle West"; illustrated by pictures of persons and places of importance. A rising vote of thanks was given to Dr. Juettner.

Wednesday, November 18.—Dr. Holden presided; about 60 members present.

Dr. Cook, from the Executive Committee, reported that the status of Dr. Francis McQuillan had been considered, and it was recommended that the Society rescind its action in dropping his name from the roll of members, November 5, 1913. The recommendation was adopted.

Dr. Eliot, from the Memorial Committee, reported a sketch of Dr. Wm. F. Byrns, with resolutions, which were adopted. See page 38.

Dr. A. B. Hooe, from the Committee on Reception of the Virginia State Medical Society, reported that the committee had dis-

charged its duty ; that the meeting had been quite successful, the visitors were pleased, all expenses were paid, and about two-thirds of the amount subscribed had been returned to the subscribers. He recommended that the thanks of the Society be given to the following persons who had especially aided in the entertainment of the visitors : Surgeon General of the Army, Surgeon General of the Navy, Surgeon General of the Public Health Service, the Commandant at Fort Myer, the Commandant of the Walter Reed Hospital and the Secretary of the Chamber of Commerce of the District of Columbia. Thanks were ordered as recommended.

On motion of Dr. Mackall the thanks of the Society were also given to Dr. Hooe for his labors as chairman of the committee.

The following letter from Dr. Wellington was read :

"THE CLIFTON SPRINGS SANITARIUM,
"Clifton Springs, N. Y.

"DR. A. L. HUNT, Secretary Medical Society, Washington, D. C.

"Dear Dr. Hunt : I wish to express to you and the members of the Medical Society my deep appreciation of your kind sympathy as expressed in your letter of October 15. It has been a source of great regret to me that I have been unable during the past year to fulfil the duties of the office with which the Society honored me.

"With kindest regards to you and the members of the Society,
"I am very truly yours,
"JOHN RYDER WELLINGTON.

"November 16, 1914."

A letter from Frederick R. Green, Secretary of the Council on Health and Public Instruction, A. M. A., asking the appointment of a delegate to the Midwinter Conference on Legislation, was read. Vice President Holden was authorized to appoint the delegate.

Dr. Atkinson presented a child with Congenital absence of temporo-maxillary joints, and showed a specimen of similar condition of the left joint of another child in the same family. Discussed by Drs. W. P. Carr, D. S. Lamb, Wolfe and Atkinson.

Dr. D. S. Lamb showed the following specimens :

Specimen shown to the Society in 1897. Skull showing *bilateral ankylosis of temporo-mandibular joints.* Condyloid processes of lower jaw, firmly united to glenoid fossae. Smooth surfaces; no outlying osteophytes. From colored woman, mulatto, age 48, who had immobility of these joints for 29 years. Died of general tuberculosis. Gave history of having had some form of malarial trouble, grippe and rheumatism. Ankylosis, probably due, therefore, to chronic rheumatoid arthritis. Of course, probability of some other form of arthritis, or injury to the joint, except that the condition is bilateral. Most commonly the anky-

losis when bilateral occurs after an eruptive fever, with or without suppuration in the middle ear. This specimen is figured in the work of Marshall on Injuries and Surgical Diseases of the Mouth and Jaws.

Leontiasis ossea.—Skull of mulatto woman, from a dissecting room. No history, except that she had come from Richmond, Va., and had had syphilis. Other bones, however, were normal, except that there was an increase of fat in the cancellous tissues. The specimen was shown to the Society about twenty years ago. Condition of partial gigantism; lower jaw not affected. Has been classed as osteitis deformans, and probably correctly so. Not acromegaly; the pituitary fossa is not enlarged, and other bones not affected. Cause, probably either chronic inflammation or an inflammation repeatedly occurring; possibility of traumatism.

Skull of woodchuck, arctomys monax; upper incisors have grown to great size, and are much curved and the right one has made an opening in the left maxilla, apparently by pressure. The incisors in rodents persistently grow, but are prevented from reaching a great size by the friction of the upper against the lower teeth on their cutting edges. When this friction ceases the non-antagonized teeth keep on growing, and eventually prevent the animal from taking food and it starves to death. It will be noticed that the face bones are turned to one side, which explains the trouble.

Dr. Heitmuller read the essay of the evening, "School clinics." Discussed by Drs. E. L. Morgan, I. H. Lamb, Macatee, J. D. Thomas and Heitmuller. See page 1.

Wednesday, November 25.—Dr. Holden presided; about 75 members present.

An appropriation of $130.93 was made for the November number of the ANNALS.

Dr. Skinner introduced a resolution, which was referred to the Executive Committee.

Dr. Adam Kemble reported a case of Chronic gonorrhoea. See page 9.

Dr. Tom A. Williams read a paper entitled, "Pathogenesis and cure of epilepsy in adolescents, with cases.

Dr. R. M. Little, Medical Reserve Corps, U. S. Navy, gave his experience with the naval expedition to Mexico. See page 27.

Dr. J. J. Kaveney, Medical Reserve Corps, U. S. Navy, also gave his experience with the U. S. squadron at Puerta Plata, San Domingo. Discussed by Dr. A. B. Hooe.

Dr. Vaughan, also of the Medical Reserve Corps, U. S. Navy, was also on the program for his experience with the troops at Vera Cruz, but was unable to be present. He, however, wrote it out and it appears on page 21.

Wednesday, December 2.—Dr. Holden presided; about 235 members present.

The Treasurer reported receipts for November, $259.00; disbursements, $165.19.

Dr. G. Wythe Cook, from the Executive Committee, reported as follows:

Regarding the request from the Council of Medical Education of the A. M. A., that the Society endorse a committee on standardization of hospitals appointed by the Council, the Executive Committee recommended that the Council be informed that the Medical Society of the District of Columbia has no jurisdiction over the Committee on Standardization named by the Council of Medical Education and operating under its auspices alone.

The resolution introduced at the last meeting by Dr. Skinner was recommended with amendment, as follows:

This Society records its appreciation and approval of the earnest and exemplary efforts of Dr. W. C. Woodward, Health Officer of the District, to protect all consumers of milk in Washington against the danger from impurities with which they are at present threatened and have been for some time, and to furthermore express the thanks of the Society to the District Commissioners for their prompt and proper defense of the Health Officer in the discharge of his legitimate duties, against the unjust and unwarranted aspersions and attacks upon him by those whose actions in thus assailing him are neither commendable nor conducive to the safety of milk consumers themselves or such persons as may be committed to their charge for care and treatment.

The recommendations were adopted.

The death of Dr. G. W. Boyd was announced, and Drs. Arnold, Burch and Lochboehler were appointed on memorial.

Dr. T. A. Williams was appointed a committee to receive donations of instruments to be sent to the Belgian physicians in need of such equipment.

The following were elected officers for the year 1915:

President, Frank Leech; Vice Presidents, first, A. L. Stavely; second, A. W. Boswell; Recording Secretary, H. C. Macatee; Corresponding Secretary, A. L. Hunt; Treasurer, C. W. Franzoni; Executive Committee, Chappell, Seibert and J. Lawn Thompson.

Wednesday, December 9.—Dr. Holden presided; about 100 members present.

The memorial committee on Dr. G. W. Boyd reported resolutions, which were adopted. See page 39.

Dr. Frank Leech was proposed as a member of the Washington Academy of Sciences, and named as Vice President of the Academy, representing the Medical Society.

It was ordered that the Secretary of the Academy be informed

that the Society did not wish to participate in the publication and distribution of the directory of the Academy.

Dr. J. B. Nichols, chairman of the Committee on Public Instruction, was appointed to represent the Society at the Midwinter Conference on Medical Legislation and Public Instruction of the A. M. A.

Dr. Walter M. Brickner addressed the Society on the subject of Shoulder disability (stiff and painful shoulder); a study of its varieties and their treatment. Illustrated by lantern slides. He was given a rising vote of thanks.

Wednesday, December 16.—Vice President Holden presided; about 60 members present.

Authority was given to the Corresponding Secretary to invite Dr. Alexander G. Brown, of Richmond, Va., and Dr. Friedenwald, his associate, of Baltimore, Md., to address the Society.

Dr. T. A. Williams, Committee on Instruments for the Belgians, reported that he had received only a few instruments; would like to get more; wanted only such as were not in use by members of the Society.

An appropriation was made of $6.61 for expenses of Corresponding Secretary.

The death of Dr. Kolipinski was announced and a memorial committee appointed; Drs. D. O. Leech, Barnes and Hall. Also the death of Dr. A. F. A. King, and a memorial committee appointed; Drs. Sterling Ruffin, C. W. Richardson, Shands, Van Renssalaer, D. S. Lamb and Fry.

The meeting of January 20, 1915, was set apart as a memorial meeting to Dr. King.

Dr. T. A. Williams presented a patient showing symptoms of *Acromegaly*.—Discussed by Drs. J. D. Morgan, Roy, Stavely, O'Malley and Williams.

Dr. D. S. Lamb showed the following specimens from the Army Medical Museum; *Diseases and injuries of the pancreas:*

Acute hemorrhagic inflammation. Two specimens. One from a case of diabetes, complicated with a chronic pulmonary tuberculosis. From a man age 40. Was sick about five months, and the glycosuria was quite pronounced. The other specimen showed also fat necrosis; no history.

Hodgkin's disease. From a man, age not stated. The liver weighed 6 pounds, 2½ ounces, and was studded with nodules, varying in size from quite small to that of a hazelnut. Spleen, 16 ounces, darkly congested; contained many small peripheral infarctions. Left kidney of normal size, contained a cyst. Aortic, iliac and pelvic glands much enlarged. Head of pancreas showed nodules. Microscopical examination by Dr. J. H. Neate showed the histology of Hodgkin's disease.

Shot wound.—Bullet in head of pancreas; had struck the man's

left shoulder; fractured the left fifth rib, perforated the left lung and left lobe of liver, and lodged. Death on the eleventh day.

Dr. T. C. Martin showed a *Stomach tube* with modifications of the standard tube.

Dr. E. F. King read the paper of the evening, entitled Glycosuria. Discussed by Drs. Roy, Nichols and King.

WASHINGTON MEDICAL ANNALS.

Journal of the Medical Society of the District of Columbia.

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Editorial.

History of the Medical Society of the District of Columbia.—Price $1.00, with 25 cents added if delivered in this city or sent by mail. Address Dr. C. W. Franzoni, 605 I Street, N. W. The books are in the custody of Dr. D. S. Lamb, at the Army Medical Museum.

The Washington Medical Annals, the official organ of the Medical Society of the District of Columbia, issued the first of January, March, May, July, September and November, will publish gratuitously such information of a medical, surgical and sanitary character, changes in personnel, &c., of hospitals, dispensaries, medical schools, medical societies and other medical agencies, as would be useful and interesting to the members of the Society. Address the Chairman of the Committee on Publication, Dr. D. S. Lamb, 2114 Eighteenth St., N. W.

THE OTHER MEDICAL SOCIETIES OF THE DISTRICT OF COLUMBIA.

Alumni Medical Society of Georgetown University.—Active membership of 110; meets on the third Saturday of the month at the Medical School. Officers: W. M. Barton, President; Chas. I. Griffith, Recording Secretary; J. M. Moser, Corresponding Secretary; Ralph O'Connor, Treasurer.

CLINICAL SOCIETY.—Officers: F. L. Biscoe, President; W. J. Mallory, Vice President; E. P. Copeland, Secretary-Treasurer; Censors: L. A. Johnson and J. D. Thomas.

1915.	*Meeting Place.*	*Essayist.*	*Discussion by.*
January 11	Dr. L. H. Reichelderfer, 1721 Conn. Ave.	Dr. W. E. Clark	Dr. Nichols.
February 8	Dr. M. D. Magee, 1623 Conn. Ave.	Dr. W. J. Mallory	Dr. Clark.
March 8	Dr. A. B. Hooe, 1220 16th St.	Clinical Evening.	
April 12	Dr. T. A. Groover, Iroquois.	Dr. J. D. Thomas	Dr. Hurtt.
May 10.	Banquet.		
October 12	Dr. J. D. Thomas	Dr. C. S. White	Dr. Reichelderfer.
November 9	Dr. E. P. Copeland	Dr. W. A. Wells	Dr. Richardson.

CLINICO-PATHOLOGICAL SOCIETY.—Active membership limited to 25. Inactive membership: those who have withdrawn from active membership after 15 years. A limited honorary membership of eminent medical men. Meets on the first and third Tuesdays of the month from October to May, inclusive. Officers: President, J. D. Thomas; Vice Presidents, Loren Johnson and H. P. Parker; Secretary and Treasurer, B. M. Randolph.

FREEDMEN'S HOSPITAL MEDICAL SOCIETY.—Meets on the second Wednesday of each month from October to May, inclusive. Composed of physicians connected with the Staff of the Hospital and the Medical Faculty of Howard Medical School. E. A. Balloch, President; S. L. Carson, Vice President; C. A. Allen, Secretary-Treasurer; Committee on Program, E. A. Balloch, S. L. Carson and H. H. Hazen.

GALEN SOCIETY of the District of Columbia.—Wm. H. Littlepage, President; Harry A. Ong, Secretary.

1915.	*Place.*	*Essayist.*
January 18	Dr. Bryson, 714 Twelfth Street, N. E.	Dr. Darnall.
February 15	Dr. Copeland, The Rockingham.	Clinical.
March 15	Dr. Mallory, 1720 Connecticut Avenue.	Dr. Cox.
April 19.	Dr. Wilson, 2714 Ontario Road.	Dr. Copeland.
May 17	Dr. Spire, 1609 North Capitol Street.	Clinical.
October 18	Dr. Pfender, 304 Rhode Island Avenue, N. W.	Business Meeting. President's Address.
November 15	Dr. Henning, The Rochambeau.	Dr. Pfender.
December 20	Dr. Titus, 1730 M Street, N. W.	Clinical.

GEORGETOWN CLINICAL SOCIETY; twenty-five active members limited to graduates of the Medical Department of Georgetown University. Meets at the University Club on the third Tues-

day in the month. John Foote, President; J. Russell Verbrycke, Jr., Treasurer.

HIPPOCRATES SOCIETY, membership limited to 25, with voluntary retired members after 10 years, meets on the second Thursday of the month from October to May. Officers for the year: J. R. Verbrycke, Jr., President; C. A. Simpson, Secretary.

1915.	*Place.*	*Essayist.*
January 14	Dr. W. T. Davis	Dr. Pfender.
	January Annual Dinner.	
February 11	Dr. Groover	Dr. Rodgers.
March 11	Dr. Syme	Dr. Brandenburg.
April 14	Dr. Henning	Dr. Simpson.
May 12	Dr. Moore	Dr. White.

MEDICAL HISTORY CLUB of Washington, D. C.—Officers: President, Philip Roy; Vice-President, F. H. Garrison; Secretary, John Foote; Executive Committee, I. S. Stone, H. W. Lawson, Wm. A. White and the Officers. Members: Truman Abbe, Frank Baker, W. C. Borden, Joseph H. Bryan, G. Wythe Cook, John Foote, F. H. Garrison, Howard Hume, H. W. Lawson, W. J. Mallory, G. Brown Miller, J. D. Morgan, John B. Nichols, P. S. Roy, I. S. Stone, John D. Thomas, Wm. A. White, W. W. Wilkinson, Mathew Kollig.

MEDICAL AND SURGICAL SOCIETY of the District of Columbia.—President, John Dunlop; Vice President, H. H. Hazen; Secretary and Treasurer, L. Eliot; Asst. Secretary, L. C. Ecker; Executive Council, O. A. M. McKimmie, E. L. Morgan, L. Eliot, L. H. Reichelderfer and Ecker.

SOCIETY OF MEDICAL JURISPRUDENCE, Washington, D. C. —President, Dr. Wm. A. White; Vice President, R. Ross Perry; Secretary-Treasurer, Dr. D. P. Hickling. Meets on the second Monday of each month from October to June at University Club. Has from forty to fifty members.

SOCIETY OF OPHTHALMOLOGISTS AND OTOLOGISTS, Washington, D. C., meets the third Friday of each month from October until May, inclusive.

Officers: President, L. S. Greene; Vice President, A. B. Bennett, Jr.; Secy.-Treasurer, A. H. Kimball, The Farragut.

Active members: Drs. A. B. Bennett, Jr., J. W. Burke, V. Dabney, W. T. Davis, L. S. Greene, C. Henning, E. B. Jones, A. H. Kimball, R. S. Lamb, F. B. Loring, O. A. M. McKimmie, W. B. Mason, M. E. Miller, Mead Moore, S. B. Muncaster, W. S. Newell, J. J. Richardson, E. G. Seibert, R. R. Walker, W. A. Wells.

Inactive members: Drs. J. H. Bryan, W. K. Butler, H. S. Dye, Wm. H. Fox, W. P. Malone, H. A. Polkinhorn, C. W. Richardson, D. K. Shute, W. H. Wilmer.

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SOCIETY OF SOCIAL HYGIENE, Washington, D. C.—President, Surgeon General Stokes, U. S. Navy; Secretary, Lt. Col. J. R. Kean, U. S. Army, Surgeon General's Office. The Society has four committees, namely: Education, Venereal Diseases, Protection of Women and Children, and Psychopathology. Yearly dues, $1.00. Persons desiring to become members should address Col. Kean and state to which committee they wish to be assigned.

THERAPEUTIC SOCIETY of the District of Columbia.—Meets at the G. W. School of Pharmacy, 808 I Street, N. W., on the first Saturday in each month. G. W. Latimer, President; A. P. Tibbets, Secretary.

WALTER REED MEDICAL SOCIETY meets on the fourth Thursday of every other month, from September to May inclusive. Composed of physicians located in the eastern part of Washington. Officers: J. S. Arnold, President; H. R. Schreiber, Vice President; M. H. Prosperi, Secretary; N. E. Webb, Treasurer.

WASHINGTON MEDICAL AND SURGICAL SOCIETY.—President, Neil D. Graham; Vice President, R. R. Walker; Secretary, Walter Van Sweringen; Treasurer, Frank E. Gibson; Curator and Librarian, E. H. Egbert. Executive Committee: L. H. Taylor, Chairman; G. S. Clark, G. S. Barnhart. Program and Auditing Committee: Wm. A. Jack, Jr., Chairman; J. R. Nevitt, Walter Van Sweringen. Membership Committee: Frank E. Gibson, Chairman, Wm. P. Reeves, Caryl Burbank.

Program—1915.

Essayist.	*Date and Host.*	*To open Discussion.*
Dr. Magee	January 25, Dr. Braden	Dr. Walker.
Dr. Nevitt	February 22, Dr. Burbank	Dr. Barnes.
Dr. Reeves	March 22, Dr. Clark	Dr. Barnhart.
Dr. Shoup	April 26, Dr. Egbert	Dr. Battle.
To be selected	May—Annual Banquet.	
President's Address	October 25, Dr. Emmons	Dr. Braden.
Dr. Taylor	November 22, Dr. Frankland	Dr. Burbank.
Dr. Van Sweringen	December 20, Dr. Gibson	Dr. Clark.

WASHINGTON SOCIETY OF NERVOUS AND MENTAL DISEASES.—President, Wm. H. Hough; Vice President, Bernard Glueck; Secretary, J. J. Madigan. The Society has a limited membership of thirty, but welcomes Physicans and Surgeons interested in Neurology and Psychiatry. Meets monthly on the third Thursday at the Cosmos Club or a member's residence.

WOMEN'S MEDICAL SOCIETY of the District of Columbia. President, Sophie Nordhoff-Jung; Vice President, Ada R. Thomas; Secretary and Treasurer, A. Francis Foye; Corresponding Secretary, Margaret R. Stewart.

In July, last, a meeting was held at the Government Hospital for the Insane, to discuss plans for a Society for the Study of Psychoanalysis. Dr. White was elected Chairman *pro tem*, and Dr. O'Malley, Secretary. Drs. Glueck, Hassall and Lind were appointed Program Committee.

The Secretaries of the other Medical Societies of this District are reminded that the Annals will publish the schedules of their meetings.

The Washington Medical Annals.—Back numbers.—Members of the Society who have back numbers of the Annals, and do not intend to preserve them, are requested to send them to the Chairman of the Publication Committee. Requests for such numbers are frequently received. Address Dr. D. S. Lamb, Army Medical Museum.

The Travel Study Tour of the Travel Study Club of American Physicians to the A. M. A. meeting, San Francisco Exposition, Honolulu, Japan, the Philippines, China, and around the world, 1915. Those interested address the business manager of the McCann's Tours, 1328 Broadway and 34th Street, N. Y. City.

Dr. A. F. A. King died suddenly December 13, and Dr. Louis Kolipinski also suddenly December 15. Appropriate action will be taken by the Society. A biographical sketch of Dr. King appears on page 269, of the History of the Society and a portrait in halftone in No. 20. A sketch of Dr. Kolipinski on page 320, and halftone in No. 35.

Dr. D. S. Lamb has a number of photographs left over from the publication of the History of the Medical Society that have not been called for. These or any of them can be obtained by any member of the Society who will call at the Army Medical Museum.

The following clipping from a Washington newspaper illustrates the sometime inaccuracy of newspaper reports :

"Dr. Leech Chosen President.—George Washington University Medical Society has elected Dr. Frank Leech President ; Dr. A. L. Stebbley, First Vice-President ; Dr. A. P. Boswell, Second Vice-President ; Dr. A. L. Hust, Corresponding Secretary ; Dr. H. C. Macattee, Recording Secretary ; and Dr. Charles W. Franzon, Treasurer. Dr. J. Chappelle, Dr. E. G. Seibert, and Dr. Lawn Thompson were elected directors."

Amendments to the Constitution and By-Laws.—The following amendments have been made since the publication in Volume XII, March 1913.

Constitution.—Article V, Section 4 ; adopted Nov. 4, 1914 : before the words "Due notice" on page 142, insert "No application for membership that is rejected or withdrawn shall be renewed until after two years from the time of its rejection or withdrawal."

Section 10, same article; adopted Jan. 7, 1914: for "two years" substitute "one year."

Article VIII, Section 2, page 148, 4th line from top: for the word "disorders" substitute the word "diseases."

By-Laws.—Article VIII, Section 9, page 153: adopted Jan. 7, 1914: No member of the Staff of any hospital receiving patients in private rooms shall attend such private patient sent to the hospital by a member of the Society, not a member of the Staff, unless specifically requested to do so by the attending physycian.

Please note that the figures in Sections 7 and 8 of this article, instead of being 7 and 8 should be 5 and 6.

PHOTOGRAPHS OF MEMBERS OF THE SOCIETY. Dr. D. S. Lamb has a large number of photographs of members of the Society left over from the publication of the History of the Society. Any member desiring any of these photographs can get them by calling on Dr. Lamb at the Army Medical Museum.

BELGIAN PHYSICIANS RELIEF.—Dr. F. F. Simpson, 7048 Jemkins Arcade, Pittsburgh, Pa., Treasurer of the Committee of American Physicians for the aid of the Belgian Profession, reports the receipt to January 2, 1915, of $662.50. His letter to the ANNALS asks the publication of this fact and inferentially also asks for contributions.

DR. T. A. WILLIAMS, 1705 N St., N. W., a committee on collecting instruments for Belgian Physicians, will be glad to receive any instruments that members of the Society can spare, however old such instruments may be. Kindly send to Dr. Williams or notify him that you can contribute them.

RECENT PUBLICATIONS BY PHYSICIANS OF THE DISTRICT OF COLUMBIA.

J. F. Anderson and A. M. Stimson, P. H. S.; The Friedman treatment for tuberculosis; Hygienic Laboratory, Bulletin 99, October. Summary: The claim of Dr. F. F. Friedman to have originated a specific cure for tuberculosis is not substantiated by our investigations. The claim of Dr. Friedman that the inoculation of persons and animals with his organism is without harmful possibilities is disproved.

W. M. Barton; Non-technical differentiation of cardiac arryhythmias; *Southern Med. Jour.*, January, page 20.

H. G. Beyer, U. S. N.; Personal experience and professional observations of so-called annual physical test (1910); *Military Surgeon*, November.

Carroll Fox, P. H. S.; Public health admistration in Minnesota; Reprint 223 from Public Health Reports, October 2. Also, Siphonaptera; Hygienic Laboratory, Bull. 97, October.

H. R. Carter, P. H. S.; Malaria; lessons on the cause and prevention; Supplement 18 to Public Health Reports, July 17.

Taliaferro Clark, P. H. S.; The cause and prevalence of trachoma; *Va. Med. Semi-Mo.*, Dec. 25, page 443.

G. B. Crow, U. S. N.; Some prevailing ideas regarding the treatment of tuberculosis; *U. S. Naval Med. Bull.*, October, 1914, page 541.

V. Dabney; Vaccine therapy in ear disease; *Laryngoscope*, October.

F. F. Durrah and G. W. White; Recovery from bichloride of mercury poisoning; *Med. Record, N. Y.*, Nov. 14.

W. M. Garton, U. S. N.; Organization and station bills of U. S. Naval Hospital Ship *Solace*; *U. S. Naval Med. Bull.*, October, page 1624.

Joseph Goldberger, C. H. Waring and D. G. Willets, P. H. S.; The treatment and prevention of pellagra; Reprint 228 from Public Health Reports, October 23.

G. M. Guiteras, P. H. S.; Plague in Havana; *Jour. A. M. A.*, Jan. 2, page 29.

F. R. Hagner; Pneumatic bag pressure for controlling hemorrhage following suprapubic prostatectomy; *Surg. Gynec. and Obstet.*, November; abstracted in *Jour. A. M. A.*, Nov. 21, page 1883. Also, Anastomosis of vas deferens to epididymis of opposite side for sterility; *Surg. Gynec. and Obstet.*, December.

E. F. King; Myiasis of urinary passages; *Jour. A. M. A.*, Dec. 26, page 2285.

E. Knab and A. Busck; Mosquitoes and sewage disposal; *Amer. Jour. Trop. Dis.*, November.

Louis Kolipinski; The treatment of croupous or lobar pneumonia, in particular that including a milk diet; *Mo. Cyclop. and Med. Bull*, November, page 667.

R. E. Ledbetter, U. S. N.; Case of pityriasis rosea; *U. S. Naval Med. Bull.*, October, page 651.

F. E. McCullough, U. S. N., and J. B. Kaufman; Training School for the Hospital Corps of the Navy; same journal, October, page 555.

Arthur McDonald; Principles of criminal anthropology; *Maryland Med. Jour.*, December, and *West Va. Med. Jour.*, December, page 190.

W. J. Manning; Further work concerning a treatment of pulmonary tuberculosis which is based upon the early obliteration of blood and lymph channels formerly ramifying through the infected area; *Medical Times*, November.

Med. and Surg. Society, D. C.; *Va. Med. Semi-Mo.*, December 11, page 435, and 25, page 459.

Med. Soc. Northern Virginia; Hotel Gordon, Washington, Nov. 18.

J. F. Mitchell; Local anesthesia in relation to surgery of genito-urinary tract; *N. Y. Med. Jour.*, Nov. 7.

J. F. Moran ; The endowment of motherhood ; *Jour. A. M. A.*, Jan. 9, page 122.

H. J. Nichols, U. S. A.; Experimental typhoid infection of gallbladder in rabbit ; *Jour. Exper. Med.*, December ; abstracted in *Jour. A. M. A.*, Dec. 19, page 2259.

J. B. Nichols ; The influence of atmospheric conditions on the vital processes ; *Va. Med. Semi-Mo.*, Dec. 11, page 417.

Mary O'Malley ; Psychoses in the colored race ; *Amer. Jour. Insanity*, October.

J. W. Paxton ; Municipal versus contract street cleaning in Washington, D. C.; *Amer. Jour. Pub. Hlth.*, November.

E. B. Phelps ; The chemical disinfection of water ; Reprint 225 from Public Health Reports, Oct. 9.

T. W. Richards, U. S. N.; Nervous system and naval warfare ; *U. S. Naval Med. Bull.*, October, page 576.

Ferdinand Schmelter, U. S. A.; Sprue treated by emetin hydrochlorid ; *Jour. A. M. A.*, Jan. 2, page 53.

C. A. Simpson ; Annular serpiginous bullous eruption complicating vaccination ; *Med. Record, N. Y.*, Nov. 28.

J. W. Trask, P. H. S.; Morbidity reports and statistics ; *Jour. A. M. A.*, Nov. 21, page 1845.

E. B. Vedder, U. S. A., and W. B. Borden ; A comparison of the Wassermann and luetin reactions in 744 individuals ; same journal, Nov. 14, page 1750.

C. S. White ; Modification of technique in operation for suppurative appendicitis, based on postoperative hemorrhage ; *Surg. Gynec. and Obstet.*, November ; abstracted in *Jour. A. M. A.*, Nov. 21, page 1883.

W. A. White ; The significance of medical gatherings ; *Va. Med. Semi-Mo.*, Nov. 27, page 394.

M. I. Wilbert, P. H. S.; Drug intoxication ; Reprint 227 from Public Health Reports, Oct. 16.

A. W. Williams, U. S. A.; A portable positive pressure apparatus for administration of ether by intratracheal insufflation ; *Jour. A. M. A.*, Jan. 9, page 138.

T. A. Williams ; The treatment of psychoneurotic patients ; *Old Dom. Jour. Med. and Surg.*, November, page 179. Also, Treatment of cerebro-spinal syphilis ; *Va. Med. Semi-Mo.*, Dec. 25, page 461. Also, some remarks with illustrative cases concerning the pathogenesis of certain neuralgias in relation to inflammation, toxicosis and neurosis ; *Maryland Med. Jour.*, December, page 301. Also, Remarks on intrathecal injections as a factor in the improvement of tabetics after salvarsan ; *Alienist and Neurologist*, November. Also, Alcoholic psychoses and psychopathic drinkers ; *Lancet-Clinic*, Oct. 17. Also, The syndrome of adrenal insufficiency ; *Jour. A. M. A.*, Dec. 19, page 2203. Also. Traumatic neuroses ; *Amer. Jour. Med. Sci.*, October ; abstracted in *Old Dom. Jour. Med. and Surg.*, November, page 223 ; *Mary-*

land Med. Jour., December, page 309, and *West Va. Med. Jour.*, December, page 196.

PERSONAL NOTES.

Dr. Carl Alsberg was elected a director of the American Association for the Study and Prevention of Infant Mortality, at the meeting in Boston Nov. 12 to 14.

Dr. J. W. Bovée attended the meeting of the Philadelphia County Medical Society December 9 and took part in the discussions.

Dr. Claude Carlisle Caylor and Miss Alice Donnelly, both of Washington, were married November 18.

Dr. P. E. Garrison, U. S. Navy, transferred from the Naval Medical School to the *Solace*.

Dr. C. C. Hillman, Medical Corps, U. S. Army, ordered to duty in ambulance company at Walter Reed Hospital.

Dr. Sofie Nordhoff-Jung is reported to have established a large American Red Cross Hospital in the vicinity of Metz.

Dr. R. F. Metcalfe, Medical Corps, U. S. A., transferred from the office of attending surgeon, this city, to Fort Porter, N. Y.

Dr. Karl Osterhaus, of this city, and Miss Elizabeth Oxley Currie, of Winslow, N. S., were married December 2 in New York City.

Dr. M. A. Parsons was elected Vice President of the Association of Medical Women at the meeting in Richmond, Va., November 10.

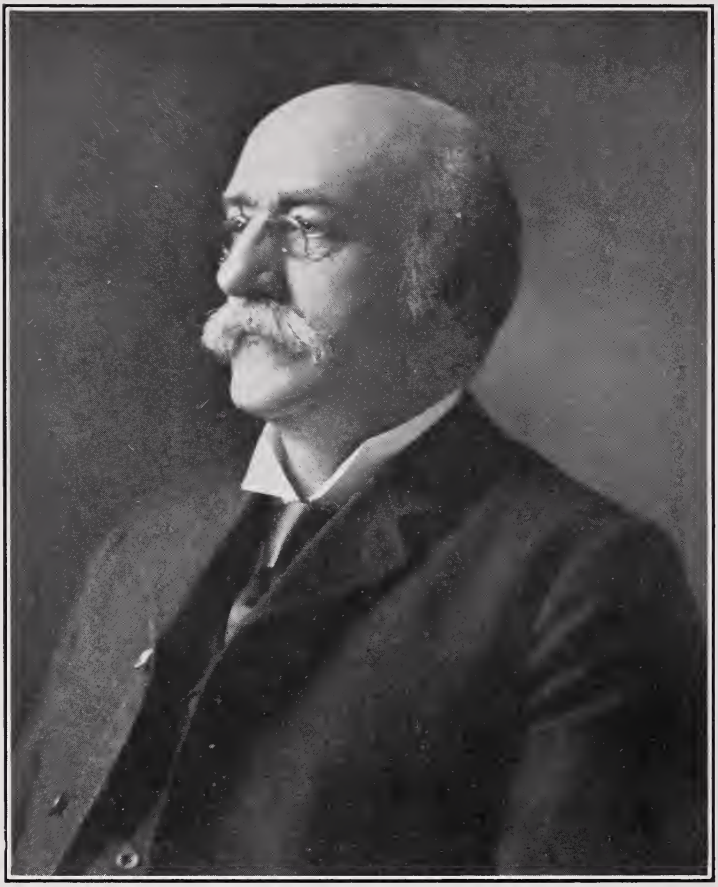
Dr. W. P. Tucker, formerly a member of this Society, died at Colorado Springs in December.

Drs. G. A. Wheeler and H. C. Yarbrough, P. H. S., ordered to the Hygienic Laboratory.

Dr. A. W. Williams, Medical Corps, U. S. A., placed in charge of the Medical Supply Depot, this city.

Dr. T. A. Williams attended the meeting of the Pennsylvania State Medical Society at Pittsburgh, September 23, and took part in the discussions.

At the meeting of the Southern Medical Association at Richmond, Va., Nov. 9 to 12, the following Washington physicians attended and took part in the proceedings: W. C. Gorgas, Surgeon General, U. S. A., John Dunlop, J. A. Ferrell, L. S. Greene, C. W. Stiles, T. A. Williams. Harvey Wiley read a paper on "The value of health;" Camp Stanley on "Duodenal alimentation;" L. O. Howard on "Plan for a campaign against malaria;" H. L. Carter, P. H. S., on "The effect of impounded water on the production of malaria; J. L. Goldberger, P. H. S., on "Etiology of pellagra;" H. H. Hazen on "Pathology and treatment of cutaneous cancer;" C. R. Dufour on "Trachoma;" W. H. Wilmer on "Sclero-corneal trephining in glaucoma."



DR. ALBERT FREEMAN AFRICANUS KING.

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WASHINGTON MEDICAL ANNALS

PRESENT CONDITIONS IN SURGERY.*

By Edward A. Balloch, A. M., M. D.,
Washington, D. C.

He would be a bold man indeed who should undertake to prophesy the future of surgery. Also would he be one ignorant of its past history. It would not be a difficult task to find in every age some exemplar of our art who, in a moment of enthusiasm, has declared his own era in surgery to be the most glorious of all time and that nothing more in the way of improvement could be expected, unless in a few unimportant particulars. For instance, I have in my possession a work on operative surgery, published in 1855, and edited by the late W. H. Van Buren, himself a shining light in the surgery of his day. In the preface it states that the work is "a complete and concise picture of the science and art of Operative Surgery in its present advanced and perfected condition." Yet the only abdominal operations described are paracentesis, the tapping of ovarian cysts and gastrotomy, which last operation is to be done only for foreign bodies in the stomach, and even then only when they can be felt from the outside. Goiter is to be treated by strangulating the gland by four subcutaneous ligatures. Curiously enough, however, there is figured an apparatus by Denan, which, in a remarkable way, anticipates the Murphy button. The principle of male and female members and of bringing the serous surfaces together between the two metal plates is the same, but suturing instead of a spring is used to hold the plates in apposition. Even the elder Gross, whose classic work was the delight of my student days, was guilty of a thoughtless utterance to the effect that surgery had nothing more to hope for in the way of advancement. Even while he was speaking, the appendix was doing its deadly work unafraid and undetected by any surgical Sherlock Holmes and the modest and shrinking fibroid had not been torn from its bed by the rude hand of the gynecologist.

Warned by these examples, I shall not venture any predictions

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as to the future, but shall ask your indulgence in the consideration of a few of the present-day problems in surgery.

There are fashions in medicine as well as in dress. At one time or another some one branch of medicine seems to occupy the medical mind to the exclusion of all others. In the dawn of our art, for instance, anatomy attracted the great minds of our profession. This was as it should be, since a knowledge of the structure of any machine should precede any experiments upon its mechanism. During my own recollection physiology was lauded, especially by our English confreres, stimulated by the work of Michael Foster and Burdon Sanderson, as the only branch of medicine worth considering. After this came a period in which the nervous system and its diseases held the center of the stage. For the past twenty-five years, however, surgery, by reason of its marvelous development and rapid progress, has occupied the medical field to the exclusion perhaps of other equally meritorious branches of the healing art. Has it reached its apogee and must it now yield precedence to some other aspirant to leadership? As I said before, I am not rash enough to venture any predictions, but I may at least go so far as to say that it seems to me that the immediate future belongs to preventive medicine. Lacking the spectacular features of surgery it is, nevertheless, doing a great work and one that is just beginning to be appreciated at its full value. It needed something like the work of Col. Gorgas at Panama to open the eyes of the people to what this branch of medicine can accomplish. None of us, I am sure, regards this as anything but right and proper, for we all recognize and admit that the end and aim of medicine is to prevent disease rather than to cure it, and that branch of medicine which deals with prevention is therefore the best exponent of true medical science. The man who shall discover a way to prevent cancer will be a greater man than all the surgeons that ever removed cancerous breasts or did gastrectomies for malignant disease of the stomach. At present, however, it is the man that is doing gastrectomies in the best and most thorough way that is doing a real service to his day and generation. He is doing the very best he can to relieve suffering humanity and that is all that can be asked of anyone.

This brings up the question—what is surgery? To some of us, blinded by the wonderful achievements of our special branch of work, it seems, no doubt, to be all that there is worth while in medicine. A moment's consideration, however, will convince the most skeptical that it is merely one branch of therapeutics, using that term in its larger sense. Its purpose is to aid in the restoration to health of those that are ill by removing diseased conditions not amenable to other forms of treatment. Like drugs, electricity, exercise and diet, it is a means to an end and not an end in itself. I fear that we often overlook this very important fact. To many in the profession and to the most of the laity, a

surgical operation seems to mean that nothing more is to be done or can be done for that particular patient. To my way of thinking a surgical operation does not restore a patient to health but merely removes some condition that was preventing that patient's restoration to health. I believe that this notion as to the finality of surgical intervention works great harm to our patients and that it is detrimental to the best interests of surgery. First of all let us understand ourselves and then give our medical friends to understand that any surgical patient needs just as careful and conscientious treatment after operation as before. If we do this I am sure that our operative results will be better than they are now. As Crile well says, "the work of the surgeon does not begin in the operating room nor with the immediate mechanical preparation of the patient for operation, nor does it end with the healing of the physical wound." I am confident that we should all be better surgeons did we bear this injunction in mind more often. The danger against which we all have to strive is that we become mere surgical carpenters, men who can make skilful repairs to a damaged human frame, and that we lose sight of the broader aims of surgery and of the interdependence of disease.

A favorite expression of our scholarly Chief Executive is that we should have the "larger vision." Surely nowhere is the larger vision more needed than in surgery today. Dazzled by the glamor which surrounds the work of our great men many are rushing into surgery without a knowledge of what true surgery really is. Needless to say this does not make for the greatest good to the greatest number of patients. Paradoxical as it may seem it is, nevertheless, perfectly true that nowadays surgery is so safe that patients suffer from this very safety. Were surgery accompanied by the risks that attended it before anesthesia and asepsis our patients would be spared many useless operations and operations would be done only by those trained to take those risks. Of course this is more than offset by the larger good that surgery has done and is doing but it is put forward in the nature of a plea for more surgical judgment in the matter of operating. It is quite apparent that many operations are being done by men who ought not to do them without more training, and that operative intervention is resorted to in cases that might yield to other therapeutic measures. The training of surgeons is lamentably deficient, owing to our lack of standards. No man can set up as a plumber until he has shown to a board of master plumbers that he is capable of doing what he will be called upon to do. To bring the matter nearer home, it is only necessary to remind you that the man who attends to your teeth must have demonstrated to a board of dentists that he was competent to do all the operations of dentistry. Not only must he be theoretically competent, but he must demonstrate that competency by doing the actual work upon the actual patient. Our eyes are rather more

important than our teeth, but is it required of an ophthalmologist that he show his ability before a jury of his peers by actual tests upon the actual patient? Not at all. Any graduate of any medical school may set up as an ophthalmologist the day after he gets his license and spoil a hatfull of eyes if he can find patients confiding enough to trust him. Is the surgical neophyte required to demonstrate his ability as a surgeon? You know the answer, and so do many of his patients. The American College of Surgeons has no more important function than the remedying of this condition, and I am sure that we shall all welcome the day when the letters F. A. C. S. shall mean Fit and Competent Surgeon as well as Fellow of the American College of Surgeons.

Some one may object here, and remind me that destructive criticism is easy, and ask me, How would you have a surgeon trained? The objection is a fair one and I shall try to answer the question, although it has been discussed extensively during the past year. This is not a discourse on medical education, nor is this the time or the place for any lengthy discussion of the subject, but I may say in brief that, to my mind, four things are necessary to the making of the complete surgeon. They are:

1. A thorough knowledge of anatomy and pathology. Modern surgery is so much a matter of skilful dissection, under the guidance of the eye, that one must know his anatomy as a prerequisite to good work. And how can one do surgery unless he understands the pathology of the conditions with which he is dealing as well as the structure of the various organs and tissues?

2. A working knowledge of all the branches of medicine. Surgery has no hard and fast limits, but is closely interwoven with general medicine.

3. Hospital training and the experience gained by assisting older surgeons. This apprenticeship is very important and should not be too brief. Were every operation to proceed along classic lines, without complications, the practice of surgery would not be so difficult, but everyone of us knows that few operations do so proceed, and it is in this very matter of dealing with unforeseen complications and emergencies that the would-be surgeon needs the most careful training. We are prone to lose sight of the fact that we do not operate for any given disease, but we operate upon patients with a given disease.

4. The close observation of the work of the masters in our art, with the emphasis on the *close*. This does not mean putting in six weeks at a post-graduate school and seeing operations at a distance of forty feet or more, but observation at close range.

I do not think that it can be said that these conditions are too prohibitive or that they cannot be met and ought not to be met by anyone intending to make surgery his life work. If necessary, the last condition could be postponed until the surgeon had been in practice a few years, but is none the less essential, as no one

man has a monopoly of good operating and every operator has some one thing which he does better than anyone else and we all learn by seeing others work.

To my way of thinking there are two classes of surgeons. In the first place there is the man of sound surgical judgment, who thinks along broad lines and whose vision takes in the entire field of our art. His contributions to surgery may be few, but they are likely to be weighty and authoritative and, in many instances, to fix standards which we all follow thereafter. He is recognized as a great thinker and one whose opinions are valuable, but he is often a poor operator. No one knows better than he just what ought to be done, but he is deficient in the manual dexterity so essential to the doing of it.

On the other hand there is the man whose fingers work with the precision of machinery and whose work it is a pleasure to watch, but who often is deficient in surgical judgment and in the knowledge of the broad, underlying principles of surgery. His contributions to surgery are likely to be mostly about matters of technique. Often he does operations that are useless. The operative work is artistically done, but the patient is no better afterward than before. We ourselves, if in need of surgical aid, would go to a man of the first class to find out what should be done and to one of the second class to get it done. Occasionally there arises a man combining sound surgical judgment with fingers that obey his will, and then we have the surgical genius.

Some of you may be expecting that I should say something about fee splitting, and indeed a discussion of present-day surgery without an allusion to this evil would seem like the play of Hamlet with Hamlet left out. But I will spare you. Enough has been said and your ears have been wearied by constant references to this pernicious practice. All the talking in the world will not make an honest man out of a dishonest one. The only remedy we have is to make the fee-splitter lose caste in our national and local surgical societies. Put him in the position of the man who said that he knew honesty to be the best policy for he had tried both, although in this connection we should remember the words of Archbishop Whately, who said, "Honesty is the best policy, but he who is honest for that reason is not an honest man." A little vigorous action both in admitting and retaining such men in our societies would at least lessen the evil.

One other matter and I have done. Heretofore we have been dealing with generalities. Now generalities are very comforting things. They do no one any harm. Leaving generalities to themselves I submit to you this question, Why is not the Washington Surgical Society better than it is? We can assign any one of a dozen reasons, each one quieting to our consciences and each one applicable to the other man, but after all, is it not because each one of us does not do his full duty? I am sure that with very

little effort we could make our meetings more interesting than they are, although they are far from being uninteresting as it is. You can have just the kind of society that you want. If you want a live one you can have it, but it means that each one of us will have to do his share. The publication of our transactions might be of advantage, and I beg to recommend to the Council the consideration of this matter. There is plenty of good surgery being done in Washington, and there is no reason that I can see why this city should not be a surgical Mecca. This Society can help make it so. I consider it to be an imperative duty on the part of a surgeon to mingle with his fellows at every opportunity. The end and aim of this Society is to give one of those opportunities. Each of us has something that he can contribute to the general good. There are brains enough and experience enough in this Society to make it a power in the surgical world. Why not make it so? It needs only a little determination and a little pulling together to make it what it ought to be. With some forty members it is a difficult matter to get enough papers for the few meetings that we have during the year. Does this mean that we are incapable, or does it mean that we suffer from mental inertia or, in plain English, from laziness? Far be it from me to accuse a body of men like this of incapacity.

CUTANEOUS SPOROTRICHOSIS.*

By C. Augustus Simpson, M. D.,

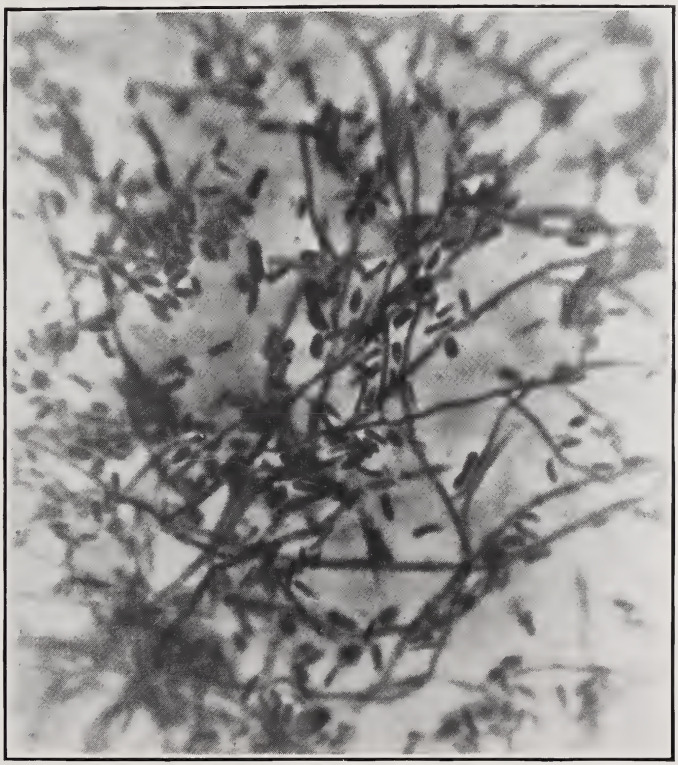
Washington, D. C.

This apparently rare though probably common disease was first recognized by Schenck, of Baltimore, in 1898. Since then over thirty cases have been reported, mostly from the middle West. The sporotrichium was cultivated and grown from each case. Besides these over thirty cases have been reported, the clinical symptoms of which pointed to sporotrichosis. In the latter cases no cultures were made, hence the proof of the diagnosis was wanting.

In France, since 1903, Burmann and Gougerot have reported many cutaneous mucous membrane, osseous, respiratory and even systemic infections of sporotrichosis. In America no such generalized cases have been seen, as here the fungus seems to be of a more attenuated form, producing only cutaneous and eye lesions. The French investigators seem to have failed to point out any morphological and biological differences between the organisms described by Burmann, Dori, Castellani, Splendere, and that first described

*Reported to the Medical Society February 3, 1915.

SPOROTHRIX GROWN ON NORTH MEDIA



Photograph shows spores and mycelia under high power. The fresh pus from the lesion showed only eosinophiles.

by and named after Schenck. The American physician is now universally proclaimed the discoverer of the disease, although the French in recent years have supplied some very valuable literature on the subject. In an examination of 57 specimens of moulds obtained by Burmann from vegetables, the sporotrichium was isolated three times. The saprophytic nature of the fungus has been demonstrated by its cultivation from various vegetable and animal structures as lettuce, hay, wheat, caterpillars and bees. In America, as in Europe, the disease is most commonly seen among farm laborers. Its apparent scarcity is no doubt due to the lack of laboratory facilities for such a class of patients as well as its confusion with late cutaneous syphilis, tuberculosis and the common pyogenic abscesses. The fact that iodide of potash is a specific for the disease no doubt helps to obscure many interesting cases in America.

Considering that sporotrichosis is a disease resembling actinomycosis in that the agricultural districts supply the majority of the cases, one would expect it to occur more frequently among the Southern people and especially the negro. I believe the present case to be the first one reported as occurring in the negro. I am indebted to Dr. Prentiss for asking me to see the case, as the patient came under his care when she visited Doctor Carr's surgical clinic at the Emergency Hospital.

The main facts of the history are that she was a colored girl, born in Virginia, 22 years of age and a cook by occupation. She had spent three years in the District, making occasional visits home but had not been out of Washington for six months. This is pretty definite proof that she contracted the infection in this city.

The disease began early in March, 1914, as a small, rather deeply seated nodule on the upper, internal, flexor surface of the forearm. It gave rise to a few subjective symptoms but continued to increase in size. She claims to have had no injury, wound or contusion preceding the first tumor. One week after the first lesion appeared another one developed one inch and a half above the first and in a line with the deep lymphatics of the arm. In another week two more similar lesions appeared, one above the other and about one inch apart. The condition now rapidly became worse, so that when I first saw the patient she had ten tumor-like formations reaching in a straight line from below the elbow to the axilla. At this time the lower and larger tumor had broken down into a deep, irregular ulcer one inch in diameter and one-fourth of an inch deep. Its edges were undermined, jagged and necrotic, its floor uneven, raw, presenting many bleeding points, all bathed with a thick, gelatinous, pussy secretion which overflowed the edges of the ulcer. The lesion just above the ulcer was as large as a walnut and projected as a hemispherical swelling fully half an inch above the surface of the arm.

On palpation it was found to be tender, soft and fluctuating, resembling an unruptured syphilitic gumma. The upper nodules at this time were hard, indurated, elevated, isolated, slightly painful tumors ranging in size from a small walnut to a pea, those nearest the axilla being the smaller. The axillary glands were but slightly if at all enlarged. The patient's general health was apparently unaffected, the local tenderness in the ulcer and the larger tumors being her only inconvenience.

Diagnosis.—Taking into consideration the patient's occupation, the duration, location and distribution of the lesions, the lack of fever, rapid pulse or other systemic symptoms, the sluggish progress of the disease and the fact that the lesions followed the course of the lymphatics without great enlargement of the lymphatic glands of the arm or axilla, I considered a clinical diagnosis of cutaneous sporotrichosis justifiable.

The lower fluctuating tumor was incised under aseptic conditions and several plate and tube gelatin cultures were made. Some of the abscess contents were also taken to Doctor Stitt of the Navy. He incubated the cultures for six days before getting a good growth, after which he isolated the Schenckii organism and confirmed the clinical diagnosis. The fungus will grow on almost any gelatin or modified gelatin media at room temperature. It may take seven or eight days to get a good growth, hence cultures should be kept under observation for at least eight days. Failure to do this prevented a diagnosis being made in one case on record. The surgeons in particular should learn to recognize the disease, as it is no doubt becoming quite common in America and is easily mistaken for a condition requiring surgical attention.

I want to thank Drs. Prentiss, Marino and Stitt for their courtesy in connection with the case.

Dr. Prentiss said that the patient whose case Dr. Simpson had just reported had come into the surgical clinic at the Emergency Hospital and thus had come under his, Dr. Prentiss', care. The lesions found were those described by Dr. Simpson ; they were distributed along the line of the deep lymphatics, but their development was not accompanied by fever nor the other signs of an acute suppurative process ; it seemed clear, therefore, to Dr. Prentiss that he was dealing with an infection differing from the ordinary bacterial infections. On this account Dr. Simpson was called into the case and the correct diagnosis finally arrived at.

Dr. Stanley inquired if the sporothrix grows artificially like a mould. His reason for making the inquiry was that last year he had worked up a case of streptothrix fosteri, a mould recovered from the stomach. He wished also to know if the organism in Dr. Simpson's case was pathogenic to animals ; the mould in Dr. Stanley's case killed guinea pigs.

Dr. Simpson said that there are many cases of sporotricha in-

fection but they are not recognized as such. Sutton, of Kansas City, recognized a case a few years ago, and since becoming interested has found very many cases in the State of Kansas. Since 1903 this infection has been the subject of study in France, and there are already over 200 cases in French medical literature. The growth looks like the ray fungus under low magnification ; with high-power lenses, however, the mycelium and spores appear. The organism will grow on any gelatin medium, but it may take six or eight days to appear ; care should be taken, therefore, not to jump at the conclusion that the implantation has failed. The organism is pathogenic to animals, particularly to white rabbits.

CASE OF SYRINGOMYELIA.*

By Tom A. Williams, M. D., C. M. (Edin.),

Washington, D. C.

A man aged 57 was referred to me by Dr. W. B. Carr, December, 1914, because of loss of power in the hand, which had lasted for six weeks ; supposed by others to be due to neuritis. According to his first story, this condition had occurred thrice in the previous six years, each time lasting a week or so. He had been in the Garfield Hospital last summer, and had been discharged "well," although later he complained of some pain for several months. He has had a severe cold since September.

His complaint is that he has a cold, numb feeling in his fingers and cannot manipulate properly, and his fingers go where he does not want them to. With the left hand he cannot even button his collar or pick up objects. There was no pain and he denied any other disease, except piles and what he called a fistula, which was never examined, and is now quite well.

Examination showed a pulse rate of 41, great weakness of the grasp and of wrist flexion, some weakness of the other wrist movements and of the *interossei*, which showed atrophy, as did the forearms somewhat. The reflexes in the upper limbs were weak ; normal in the lower limbs ; the pupils reacted normally. The stereognosis was defective and the sense of attitude was impaired in the right hand and elbow.

The sensibility was extensively impaired as regards pain and temperature, and somewhat as regards spacing and vibration ; it was normal to touch. The impairment occurred over the radial portions of each forearm and extended to the trunk as far down as the 10th thoracic segment, and there was diminution to deep pain, especially on the left side. Diminution to pinprick was

* Reported to the Medical Society, January 13, 1915.

very marked on the chest as far as the nipple, less so to the 10th thoracic segment. The sensibility to cold was diminished, more especially in this area. Pinprick was unfelt in the neck as far as the line of the 5th nerve, but cold was everywhere felt; sensibility to heat was similar but not coterminous with that to cold. There was an area of hyperesthesia over the back of the left metacarpus, size of a half dollar; a prick there provoking a sensation radiating to the finger tips. Around the left wrist there was a one-inch wide strip of normal sensation, while the hand especially was slightly hypoesthetic, and in the right arm there was in addition to the radial loss, a narrow strip along the ulnar border of diminished sensibility to pinprick. The vibration sense was diminished in the left arm up to the clavicle, especially radially and markedly over the thumb; on the right side there was possibly a diminution in the mid-ulnar border. Spacing sense: points 9 m.m. apart were nearly always felt as one on the left finger tips, whereas in the right hand they were nearly always correctly felt as two, except in the thumb. Points 13 m.m. apart were generally distinguished as two. No muscle twitchings have been noticed in the arms and hands, but he has noticed them in the back of the neck for some years.

Before localizing the lesion, whatever its nature, the position of the sensory tracts in the cord and the segments of cord supplying different parts of the body, must be clear in one's mind. The parts of the body supplied by different cord segments have been carefully worked out by different observers. According to their charts, the 3d cervical to 4th dorsal segments supply the arms, shoulders, neck and chest both anteriorly and posteriorly. These are portions of the body affected in this man and locate the lesion of segments named.

The fibers concerned in muscular sense go up in posterior columns and direct cerebellar tract on the same side as that which they enter. Temperature and pain fibers enter posterior root, cross to opposite side of commissure of gray matter and go upward in antero-lateral column of cord. Touch fibers pursue a more wide-spread course. Part of them pass in through the posterior root and go upwards in posterior column. The remainder, entering the cord with those just mentioned, soon cross the median line through the commissure and go upward in antero-lateral column of opposite side.

The next step is to locate the position in this part of the cord of a lesion which will account for the sensory changes and slight atrophy here present. The lesion must be one which will cause bilateral diminution of temperature and pain sense, no disturbance of touch sense, and cause slight muscle atrophy with no increase of reflexes.

Such a spot is found in the commissure of the cord near the central canal where the fibers of pain and temperature decussate;

the difference in degree of loss on the two sides being explained by supposing the lesion to be situated slightly to one side of the center of the cord. That touch sense is not interfered with even though many fibers here decussate, is explained by the fact that very many of them, enough to preserve this sensation unimpaired, do not cross but go up in posterior columns of same side.

The atrophy here present must be accounted for, and this is explained by supposing the lesion to involve to some extent the anterior horn cells or their axones in the region mentioned, especially in 7th and 8th cervical, as these are segments which supply the small muscles of the hand.

Having thus located the lesion in the cord around the central canal in the region extending from 3d cervical to 4th dorsal segments, it remains to determine if possible the precise nature of the lesion.

A haematocele in this place would give similar symptoms but its onset would be sudden and the tendency would be to a rapid improvement. The history here is of a chronic case running over a period of six years.

Caries of spine may present a somewhat similar picture, but if present, would be accompanied by symptoms of vertebral disease, none of which are here present. If the cord were compressed, spasticity would be present and dissociation would be less marked.

Pachymeningitis, if tubercular, would show remissions in course when put under proper treatment, but would show more pain at onset. Besides, in so extensive an involvement of the segments of cord as is here present, it is hardly to be supposed that the pyramidal tracts would escape pressure, which would be shown by the condition of the reflexes. If only the spinal roots were implicated their dissociation would be less complete and constant dull atrophy would be wider spread.

Chronic pachymeningitis, due to other causes such as syphilis, can be dismissed for similar reasons.

Acute cervical pachymeningitis can be similarly ruled out because this case presents no severe pain, rigidity or fixed position in neck, and also because of the dissociation of sensation which is present.

Peripheral neuritis presents hyperesthesia, pain and tender nerve trunks and deep tissues which are not found in this patient.

The atrophy present and its progressiveness suggest Progressive Muscular Atrophy. In that condition, however, the noninvolvement of sensation and its progressive course, set it aside, as in this case sensation is involved and the course of the disease has not been steadily progressive but has shown remissions.

If central arteritis be suggested as a cause, the anatomy of the circulation in this part of the cord must be remembered. The anterior spinal artery gives two branches which penetrate the

anterior fissure at right angles and enter the cord going to right and left anterior horns supplying also the corresponding pyramidal tracts. An obliterative process in one of the two branches will give a unilateral disturbance affecting both anterior horns and the pyramidal tracts. This means that all reflexes below site of lesion would be increased, which is not the case. If both branches had the same process there would be a similar bilateral picture. It is hardly conceivable that an obliterative process could be so widespread as to involve so many segments and not give a much more extensive picture than is here present.

A tumor of the cord in this region must, of course, be considered. This is usually accompanied by pain, which is not present in this case, by increased reflexes below site of tumor, which we do not find, and by a steadily progressive course, which is not here present. And, too, tumors of the cord are usually limited to two or three segments while here at least six or seven are involved.

Lateral sclerosis of the amyotrophic type now presents itself for consideration. If that were present the picture would be one of increased reflexes, early spastic gait and intact sensations, together with a steadily progressive course with never a remission. This picture is very different; for sensation is disturbed, the gait is normal, reflexes are not increased and remissions have occurred.

Another condition remains for consideration, *i. e.*, Syringomyelia, a disease of the spinal cord characterized by the presence of cysts near the central canal. These cysts are the result of a degeneration of a preceding gliomatous tumor. The tumors, and the cysts which follow as a result of tumor degeneration, are described as occurring in the very region of cord in which must be located the lesion to give rise to the syndrome presented by this man. Dissociation of sensation (touch being present, temperature and pain being lost), atrophy of muscles occurring most frequently in small muscles of hands, reflexes undisturbed or slightly diminished, muscular weakness in regions affected, is the clinical picture. And we see its counterpart in this patient.

Hence we conclude that this man is suffering from Syringomyelia, the lesion being that of cyst formation in the gray matter of cord near the central canal, and the segments affected being those from 3d cervical to 4th dorsal, the process being most extensive in the 7th and 8th cervical segments.

Dr. John D. Thomas said that Dr. Williams had spoken of a case of this disease presented by him [Dr. Thomas] to this Society several years ago. The patient had been given x-ray treatment by Dr. Groover; for a time, while there was no improvement, no progress of the disease was noted. At the present time, however, there has been a very distinct advance of the disease, treatment having been suspended on account of an x-ray burn.

Dr. A. B. Hooe asked what prognosis should be given in the case exhibited, especially having in view the very good condition of the patient?

Dr. Williams said that the ultimate outlook for this patient was very bad ; the duration of the disease is usually very long, however, and the symptoms may remain nearly constant for as long as twenty years, little progress being noted.

As for x-ray treatment of this condition, we have not yet developed definite rules for therapy. There has been little success in this country with this form of treatment ; the lack of success may be due to faulty technic ; better results have been achieved in France. It has been proved that we may induce a hypoplasia of the thyroid by x-ray exposure, but not in all cases. If we have some failures in attempting to reduce a superficial gland like the thyroid by Roentgen irradiation, *a fortiori* we should expect failures from like treatment of a deep-seated gliosis in the heart of the spinal cord.

SUBCONJUNCTIVAL INJECTIONS OF SALVARSANIZED SERUM IN THE TREATMENT OF OCULAR DISEASES DUE TO SYPHILIS.*

By Robert Scott Lamb, M. D., F. A. C. S.,

Washington, D. C.

Following a paper entitled " Intraspinous Injection of Salvarsanized Serum in the Treatment of Syphilis of the Nervous System, including Tabes and Paresis, Abstract," read before this Medical Society, October, 1913, by Dr. Hough, my colleague, Dr. E. G. Seibert, who had heard the paper, suggested to me and discussed with me the possible use of the serum, subconjunctivally, in syphilitic lesions of the eye. The basis of his argument was that the condition of the circulation, more especially in the cornea of the eye, was similar to conditions occurring in the brain, in that nutrition depended entirely upon the lymph. The bloodvessels under normal conditions do not penetrate much beyond the edge of the sclero-corneal margin. In view of the fact that the treponema pallida seeks those lymph spaces which are farthest from the capillaries, and as it has been found necessary in paraluetic diseases of the nervous system to fight them by a more direct route than the blood with intravenous injections, he believed that in such conditions as, for instance, interstitial keratitis, the patients would be benefited by the subconjunctival injections of salvarsanized serum.

* Read before the Medical Society, February 17, 1915.

The suggestion appealed to me, and because of a wide experience with injections of normal salt solution, throughout a period of years, it seemed to me that perhaps other conditions which had not responded so well to intravenous injections might receive supplementary treatment through these local subconjunctival injections.

Having an unusual opportunity with large clinical practice to make investigations, I proceeded to use this serum, obtained, according to the suggestion of Dr. Hough, through the kindness of Dr. Van Swearingen, and sometimes from Dr. Hough himself. The directions as I understand them are quoted as follows:

"A dose of salvarsan or neosalvarsan is given intravenously in the usual manner. At the end of an hour, 50–60, or even 100 c.c. of the patient's blood are drawn by means of venous puncture; clear serum thus separated, allowed to stand an hour, then centrifugalized, is diluted 40 per cent. with normal salt solution, heated to 56 C., for half an hour; then either hermetically sealed in ampoules or kept cool until the following day, when it is put in ampoules, capacity 1 c.c., and kept on ice a reasonable length of time, to be used whenever needed. It is warmed to the body temperature before using."

In May, last year, while attending a meeting of The American Ophthalmological Society, at Hot Springs, I spoke to Dr. Holloway, of Philadelphia, telling him of the work I had already done along the line of subconjunctival injections with the serum, and he said he had not, at that time, found any statement regarding any such treatment. Later on, the 18th of May, he gave me two references which I have attempted to get hold of; but owing to the war, the Surgeon General's Library could not furnish me with copies. From his letter I take it that he had not seen the articles, but had only read the references in "Ophthalmic Literature." Up to the present time I have seen no record of the use of salvarsanized serum by subconjunctival injection.

It has been my pleasure and good fortune to have been able to use this serum in numerous cases—interstitial keratitis, iritis, gummatous iritis, irido-cyclitis, chorio-retinitis and even in optic atrophy, accompanied by chorio-retinitis.

The results are not disappointing, at times the results were so rapid as to be almost startling. It would be wearisome to report a great number of these cases, and hardly profitable, in view of the fact that the main point I wish to bring out is that salvarsanized serum used subconjunctivally in the treatment of syphilitic conditions of the eye, induces rapid recovery, and in some cases, I feel sure, has made recovery possible, where the use of the ordinary methods of treatment, even including intravenous injections of salvarsan, were unavailing.

As anaphylaxis does not occur in the use of these salvarsanized

serums, I have obtained the serum where it was possible, from patients, and used it on them or on other patients. So far as I can see there is no difference in the action so long as it is human salvarsanized serum.

Some cases come to my mind to illustrate the possibilities of this serum. One was a young colored man, mulatto, who had been treated for 2½ or 3 months with the usual remedies, and whose eyes were cleared up, except for posterior synechiae which were numerous in each eye. These had resisted dilatation with atropin and absorption by means of local and internal measures. After two injections of salvarsanized serum, ten days apart, these adhesions had all disappeared and the pupils were widely dilated under atropin.

Another case, a very striking one, in which some months before the patient had had an inflammation in one eye, which had been completely lost except for light perception, by occlusion-iritis. He was brought to me with gummatous iritis of the other eye; there were one large gumma and two small ones in the iris. After the first injection one of the small ones disappeared, the second small one almost disappeared, and the third large one was reduced to half its size. After the second injection the second small one entirely disappeared and the large one became still smaller. Although the internal medication was continued, a lapse in the treatment occurred, owing to my own illness, and when I saw him again he was suffering the excruciating pain which is common in these cases. But after one injection, the iritis which had recurred, subsided and the remaining portion of the gumma was very much reduced in size. Another injection completely absorbed the gummatous tissue.

A third case of double plastic irido-cyclitis of both eyes had been treated for three weeks when I saw him. The right eye had posterior synechiae; the left eye had marked posterior synechiae with a gumma, which was a very, very large one. The first injection cleared the right eye of the posterior synechiae, the left was partially benefited and the second and third injections improved the left eye, which finally healed, inflammation having subsided, with adhesions between that portion of the iris which had been gummatous and the anterior capsule of the lens.

Mention should be made of a case of interstitial keratitis which came to me from Chattanooga and was cured within three and one-half months, more thoroughly than most cases which were wont to take as much as two years; the scars being almost invisible.

These cases, which had resisted all the drastic measures, including the intravenous injections of salvarsan, should be sufficient to illustrate the efficacy of the treatment. I have numerous other cases, varying in degree of severity, and, from the results of the

use of salvarsanized serum in these cases, I feel perfectly safe in saying that in all but the optic atrophy cases there was decided benefit; and in a few of these cases of optic atrophy there seemed, at least, some improvement which was maintained throughout the period that the patient was under observation.

As to conclusions: I may suggest that you take this evidence, consider it well, then try it for yourselves and see if you can get as enthusiastic about it as I am now, after more than a year's experience in the use, subconjunctivally, of salvarsanized serum for the treatment of ocular manifestations of syphilis.

Dr. Seibert said that when a year or two ago Dr. Hough read a paper before the George Washington Medical Society on Cerebral Syphilis, Dr. Seibert had been struck by the similarity between syphilitic diseases of the brain and luetic affections of the eye; both classes of manifestations being singularly resistant to antiluetic treatment administered by the ordinary routes, and both offering the same explanation for this behavior, namely, that in both structures the nutrition is provided by means of terminal bloodvessels. The conditions are especially similar in chorioretinitis and in kerato-iritis. It seemed to him reasonable that if intrathecal injections of salvarsanized serum were productive of so much good in cerebral syphilis, subconjunctival injections of a like serum would be helpful in ocular syphilis. He obtained some salvarsanized serum from Dr. Hough and injected it under the conjunctiva in suitable cases, with remarkably good results. The reaction produced by the injections did not differ from that seen after subconjunctival injections of salt solution. He early communicated the idea and the results in his few cases to the Washington Ophthalmological Society December 19, 1913. Dr. Lamb, who had at his disposal a very large amount of clinical material, at once took up the work with the uniformly good results reported tonight.

Dr. W. T. Davis had listened to the paper and had examined the patients with great interest. The method would appear to mark a great advance in the treatment of these stubborn ocular diseases. Without any desire to be critical, he wished to ask one question: We know that interstitial keratitis is usually due to luetic infection; we also know that these cases tend to clear up spontaneously; we know furthermore that intravenous injections of salvarsan do not materially help eye cases of this sort; may not the results in some of the cases reported be the same as the helpful results following simple subconjunctival injections of salt solution?

Dr. Roy asked if normal blood serum had been used in any cases for control purposes? We know that there is very little salvarsan present in the serum withdrawn after the intravenous

dose of the drug; some of the workers have found it necessary to fortify the serum with more salvarsan before injecting it into the spinal canal.

Dr. Hough said that it had been shown by Ehrlich and others that salvarsanized serum has a distinct treponemacidal power, a power greater than that exerted by salvarsan itself. There may be in serum so treated a certain biological effect not to be measured solely by the chemical proportion of salvarsan present. Dr. Hough cited some cases to illustrate this power of salvarsanized serum, notably a case which had been found to be Wassermann-fast after the most strenuous intravenous treatment with salvarsan; one injection of the salvarsanized serum into the spinal canal brought the Wassermann reaction to plus-minus (blood serum reaction). He controls his cases with salt solution and with normal serum; the problem is large and important; workers upon it therefore should go slowly and carefully control every case.

Dr. Huntington asked if the Wassermann reaction was used in the recognition of the cases reported; whether the serum employed was autogenous and if so, could the salvarsan given be excluded as the source of improvement; and whether, in the cases of optic atrophy, the improvement in vision was in the center of vision or only in the periphery.

Dr. Lamb thanked the speakers for their remarks. He thought it would be taken for granted that all diagnostic helps would be used and all controls employed before bringing a new method before a medical society and thus exposing himself to possible criticism. Certainly the Wassermann reaction had been obtained in these cases, in some of them quadruple plus. Although he had approached this method of treatment with skepticism, he now believes thoroughly in it; he invited all oculists simply to give the method a trial and he felt confident that conviction would follow.

A PLEA FOR A CANCER CLINIC.*

By S. R. Karpeles, M. D.,

Washington, D. C.

If a disease which has claimed a million victims in the United States in the last fifteen years and ranks only second to tuberculosis in the adult mortality lists, does not inspire our supreme efforts, then the object of this paper is a failure. I refer to cancer.

We have evidence that cancer was known at a very early period. The Egyptians in 1500 B. C. treated an ulcerating disease with arsenic salve, and about 800 B. C. cancer of the breast

* Read before the Medical Society, January 13, 1915.

was extirpated in India. The ancient Greeks had a very good clinical idea of the nature of cancer, for Hippocrates (470–361 B. C.) said "What drugs fail to cure, the iron (knife) cures; what the iron cures not, that the fire cures; but what the fire fails to cure, this must be called incurable." Galen (131–204 A. D.) taught that cancer was the result of a humor. Leonides (180 B. C.) actually practiced with the knife and cautery. From this time until the Renaissance no progress was made in medicine. Guy DeChauliac (1300 A. D.) taught that cancer was allied to leprosy and used the thermocautery. Jansen (about 1590) is said to have devised the compound microscope and thus paved the way for the future. Hunter (1728–93) is credited with being the first man to study the minute structure of tumors. The perfection of the microscope in 1831 was followed in 1838 by the publication of the first important work on cancer from a histologic standpoint by Muller, and it was not until 1858 that Virchow applied his famous aphorism "Omnis cellula e cellula" to the etiologic view of tumors. From this sprung the doctrine of Cohnheim, which well explains many tumor formations.

The subject of cancer may be said to be the greatest problem of the day. Throughout the world, in nearly every country in Europe, and every State in the United States, hospitals, research foundations, local and international cancer societies are unremittingly devoting the greatest minds to a solution of the all-important question.

It has been alleged on the continent in Europe, in the British Isles and in the United States, that cancer is increasing. This brings us to a discussion of the question whether the increase is real or only apparent. Dr. H. P. Dunn in the *British Medical Journal* of 1883, concluded "in the face of incontrovertible facts cancer is increasing in England." Dr. George King in the *Proceedings of the Royal Society,* London, 1893, asserts that it is generally assumed by the medical profession that cancer has increased, and quotes from the Registrar's Report 1889, "It seems scarcely possible to maintain the optimistic view that the whole of the apparent increase can be explained by increased accuracy, and it must be admitted as at any rate highly probable that a real increase is taking place in the frequency of these malignant affections." Nevertheless, Dr. King concludes, the increase in cancer is only apparent and not real, and is due to the improvement in diagnosis and more careful certification of the causes of death. This is shown by the fact that the increase has taken place in inaccessible cancer, difficult of diagnosis, while accessible cancer easily diagnosed has remained practically stationary. Dr. Roswell Park in the *New York Medical News,* 1899, says: "That the death rate is increasing throughout the world, this increase will continue until its minute causes are determined. It is the

only disease that is steadily increasing." An excellent editorial in the *Journal of the American Medical Association,* 1910, states, that statistics in regard to increase should be made with conservatism and accepted with caution; early vital statistics are incomplete, later ones are not as exact as desired.

The United States Census Report for 1913 will say, "Cancer showed in 1913 an increased number of deaths, 49,928, and an increased death rate, 78.9, as compared with the preceding year (46,531: 77 per 100,000 population). The death rate from this cause was higher than that shown for any previous year, and marks an increase of about 20 per cent. in the crude mortality as compared with that of ten or fifteen years ago; 5.6 per cent. of all deaths were due to cancer. The constant increase in the general cancer death rate is an almost universal phenomenon of mortality statistics. I concede we have today better diagnosis, increased longevity, decreased infant mortality, and more exact statistics. But we must not lose sight of the increase in the number of cancers surgically cured, and from an investigation of only the smallest portion of the enormous literature, I feel that we must agree with such men as Czerny, of Germany, Coley, Park and Bainbridge, in this country, as to the real increase in cancer.

In the report of the Health Officer of the District of Columbia, the word "cancer" is used in its popular sense, covering all forms of malignant tumors. The report will state that such tumors killed during the calendar year 1913, 351 persons, the corresponding death rate being 99.28. At present one death in every seventeen is due to this malady. That there has been a marked increase in the prevalence of such growths is shown by the fact that from 1896–1900 the rate was 61.3 against 99.28 per 100,000 population today.

The last yearly report of the following local hospitals, Columbia, Freedmen's, Garfield, Georgetown University, George Washington University, Homeopathic, Providence and Sibley, showed that they admitted 15,565 patients of which 424, or 2.72 per cent., were affected with malignant growths. In round numbers I should say that about 500 cancer cases were treated in the hospitals of Washington during the last year. During the past fifteen years there were admitted at Garfield Hospital 23,708 patients, of which 516, or 2.18 per cent., had cancer; at Freedmen's Hospital 41,050, of whom 610, or 1.48 per cent., had cancer. Thus the per cent. average of these two hospitals 1.83 per cent. against 2.72 per cent. quoted above, shows a marked increase.

Since the first publication of the WASHINGTON MEDICAL ANNALS, in 1902, seven essays have appeared in its columns, by Drs. Reyburn, Wood, I. H. Lamb, Smith, King and Abbe, yet none of these has aroused the local medical society to a proper appreciation of the gravity of the "Cancer Problem." One out

of every seventeen deaths in the District of Columbia was caused by cancer. Generally speaking, one of every eight women and one of every eleven men who reach adult life will die after a merciless torture of months or years, of this most dreaded of all diseases. For about twenty-five years Prof. Winter, in Germany, has waged an unremitting campaign for the education of the laity and profession. Equally eminent men in Europe and in our country have done likewise. As far as I am aware no such move has taken place in the District of Columbia. I have no doubt that the findings of the commission on cancer appointed by the Pennsylvania Medical Society in 1911 would apply locally. The report shows that throughout the State superficial cancer has been apparent on an average of eighteen months before the case came to a surgeon, eleven months has elapsed from the time a physician has been consulted until the date of operation. In deep cancer this time is one year. About one case in thirty of breast cancer was not even examined by the first physician who saw the case; in one case in six, salves, ointments, etc., were prescribed with advice to temporize. Only 68 per cent. of the superficial and 48 per cent. of the deep-seated cancers are operable when they come to the surgeon.

There is no justification for temporizing with a disease that inevitably proves fatal if left alone. I am sure I will be pardoned if I quote the following editorial from the *Journal of the American Medical Association:* "As in tuberculosis, so in cancer, the education of the public is our most important weapon in the fight, and education in the early manifestations of the disease is the great desideratum." Here I shall add "Physician, heal thyself." As far as we are concerned the disease must be diagnosed in the pre-cancerous or early malignant stage, otherwise the prognosis is death. To accomplish this I assert that every physician must become a cancer specialist. The dermatologist sees and recognizes his epithelioma, the laryngologist uses the laryngoscope, the surgeon feels a "lump" in the breast, the gastro-enterologist examines the gastric and intestinal contents, the urologist has the cystoscope, the proctologist, the proctoscope and the gynecologist makes a digital and speculum examination. These professional brothers, having the welfare of the masses at heart, must instruct the general practitioner in the simplicity of the use of their instruments and methods of precision. Here in Washington we have as excellent medical men as anywhere in the world, likewise I will concede no second place for our hospitals. A biweekly "Cancer Clinic" in practical diagnosis will so improve the local medical fraternity that the solution of the "Cancer Problem" will be as advanced here as anywhere in the world.

Resumè: 1. Cancer is on the increase. 2. Every adult patient presenting any of the suspicious symptoms should be classified as

a "Cancer suspect" until proved cancer free. 3. The treatment is the earliest radical operation. 4. A committee should be appointed by the Medical Society to actively combat the "Cancer problem" and establish the "Cancer Clinic."

Dr. Kober expressed his deep appreciation of the paper and the recommendations it contained; he hoped the recommendations would be referred to the Executive Committee. The subject needs consideration not only from the standpoint of cure but also from the standpoint of prevention. If education has been able to accomplish so much in the prevention of tuberculosis, the same mode of attack should be adopted for the cancer problem.

Dr. Gannon said that Dr. Karpeles was to be congratulated on the paper. Dr. Gannon was especially interested because of the very large proportion of cancer cases to be found in the wards of the Washington Asylum Hospital. He cited the sad case of a woman in that hospital at this time with an ulcerated, sloughing cancerous breast, begging for relief and without hope of recovery; she had been in the hands of six physicians and none had advised operation.

Dr. A. B. Hooe said that the paper was most timely. A very large proportion of the inoperable cancers have been seen by practitioners during the operable stage and no radical measures have been advised. One erroneous impression prevails and may do much harm; namely, that cancer does not occur in young persons. He had been astonished at the figures compiled at St. Mary's Hospital, Rochester, Minn.; the statistics include carcinomatous growths from babies. He cited several cases of cancer in very young persons. He expressed the hope that the matter would be referred to an appropriate committee for further action.

Dr. Williams said that every physician knows the ravages of cancer; every physician deplores them; every physician wishes to limit them as far as possible. Even neurologists see cases which impress them with the prevalence of this disease. But is a special clinic the best method for combatting the extension of the disease? Is not education better? Education especially of students of medicine in the schools and of practitioners in the medical societies? Is it not better to increase the strength of existing hospitals than to create a new agency? Is it not better to secure an intelligent public appreciation of the known facts with regard to cancer? And is it not the proper duty of the already existing Committee on Public Instruction to undertake to indoctrinate the public with these facts? Why should a special committee and a new clinic be created when clinics and a committee already exist? It would seem clear that the matter would be disposed of if the Committee on Public Instruction would only instruct, and the instructed profession and public would only coöperate in the clinics.

Dr. J. Lawn Thompson said that Dr. Hooe's remarks upon the large proportion of cases of inoperable cancer which had been recognized by physicians during the operable stage constituted an aspersion upon the whole profession. It is true that there should be no such cases ; but when the press tends to foster the idea that cure for cancer can be had from radium or from x-rays or from any other method promulgated and advocated by isolated medical enthusiasts, just so long will the profession be unable to induce the layman to invoke radical surgical aid during the early stages of cancer.

Dr. Chappell said that whatever aspersions may be cast upon the profession for neglect of early cancer cases, he did not take such aspersions to himself. Simply because cancer cases reach the surgeons at a period of inoperability is no reason to believe that the patients have been ill-advised by their physicians ; so long as patients conceal from themselves and from their physicians their fears with regard to new growths or alarming symptoms so long will there be such cases.

Dr. Karpeles said that his object in presenting the paper was to secure the appointment of a special committee to consider the advisability of establishing a cancer clinic along the lines advocated in the paper. At the proper time he hoped to make such a motion.

TWO CASES OF FRONTAL SINUSITIS AND THE KILLIAN OPERATION.*

By C. W. Richardson, M. D.,

Washington, D. C.

The two cases which I present tonight are for the purpose of showing the cosmetic effect of the Killian frontal sinus operation.

In the first case, that of this young man, there was the following history: Some eight years ago, he first presented himself to me with his right nasal cavity filled with nasal polypi. These were removed. At that time there was some little frontal headache. After the removal of the growths there was a slight purulent discharge from the right frontal sinus. After a period of about eight years he came back to me on account of persistent and severe frontal headaches, with quite an abundant purulent discharge from the right frontal sinus. This pain became so severe that, in spite of two or three months' treatment, operative measures were suggested and acted upon. In doing the Killian operation on this case we had one feature which I have noticed several times before, and that is, after the opening of the frontal

* Reported to the Medical Society, January 27, 1915.

plate, the pus showed itself to be under great pressure. In this operation we also had a disturbance which I have seen only once before, and that is a slight diplopia, which is now disappearing. In examining this case you will notice that this, as well as the second case I show, has a little more depression than in previous cases which I have presented to the Society. The deformity is not marked, and is only noticeable under certain lights and angles. You will observe that the line of incision is hardly to be noticed. In this first case the frontal sinus solely is infected.

In this second case, which I now present, this woman, you will find that all the sinuses were affected—the frontal, the ethmoidal, the sphenoidal, and the right antrum. The history is very similar to the first case, in that the woman came to me, with nasal growths, which filled the whole cavity. These were removed, and we found that she was suffering from a pan-sinusitis. The head pain was very severe, and was continuous. We gave a period of three or four months' treatment, after the removal of the growths, to see if we could improve the condition and relieve the head pain, but as this proved futile, she was operated on through the Killian operation in the frontal, and then a modified Caldwell-Luc operation in the antrum. In the latter, when it came to removing the internal wall of the antrum or the outer wall of the nasal chamber, I carefully dissected away the bone from the whole surface of the mucous membrane, separating it as I removed it over the area, and then after cutting away the bone, I placed the flap upon the roof and outer wall in the exposed bony cavity. You will see upon examination of this case, that she presents about as much depression as the young man and the same type of scar. They are both well, and present themselves to you for this examination.

Dr. O. Wilkinson congratulated Dr. Richardson on the beautiful results obtained in the cases exhibited. There could be no question that the Killian operation was the operation of choice in chronic frontal sinusitis, especially when complicated by nasal polypi. In subacute cases, however, removal of a portion of middle turbinate and of anterior ethmoid cells, with irrigation of the sinus, would effect a cure of 85 per cent. of the cases. In cases with a very deep frontal sinus, the osteoplastic operation of Beck is almost ideal.

Dr. McKimmie said that the presentation of these cases was illustrative of what may be done with the Killian operation in the chronic and most stubborn cases of frontal sinusitis; as a matter of fact many of Dr. Richardson's cases show even better cosmetic results than the patients who had just been exhibited. For himself he had long since come to the conclusion that it is impossible to irrigate the frontal sinus; acute cases get well

spontaneously if well drained, attempts at irrigation having nothing to do with the cure. He believes that it is dangerous and unsurgical to attempt the cure of chronic frontal sinusitis by intranasal operations. Those who see many Killian operations realize how futile it is to attempt the intranasal attack. X-ray pictures are very desirable, but if not available, the Killian operation may safely be done by reversing the steps of the second stage of the operation.

Dr. Dufour had had the pleasure of seeing Killian operate. A point he lays much stress on is the preservation of the periosteum of the superciliary ridge in order to preserve the function of the trochlea. In chronic cases Killian obtains a skiagraph first and then operates with the plate as guide. In acute cases, he removes part of the inferior turbinate and irrigates with hot antiseptic fluid. It would seem to be a good idea to have an understanding with the patient before operating, having in view the possibility of resulting deformity.

Dr. Richardson said that the patients exhibited presented the most marked deformity he had found following recent operations. He had had very many patients with no depression whatsoever. His experience is that after getting into the frontal sinus it becomes manifest that it would have been impossible to accomplish anything useful by any other operative method.

CANCER OF THE SKIN.*

By H. H. Hazen, M. D.,

Washington, D. C.

Cancer of the skin is an unnecessary disease, for it always arises from a pre-existing lesion or abnormality of the skin. The lesions from which cancer may arise are numerous; the following are the most important: The senile or seborrheic wart; various types of keratosis, it always being remembered that ordinary corns and callosities do not become malignant; cutaneous horns; pigmented moles which are subject to irritation; various types of naevi, chiefly the pigmented ones; scars of wounds which have not healed by first intention; sinuses; ulcers, but rarely leg ulcers; chronic skin diseases, of which the most important are tuberculosis, syphilis, blastomycosis, psoriasis and x-ray dermatoses; wens; subcutaneous nodules of uncertain nature, but most probably sebaceous gland infections or retention cysts.

There are several types of cutaneous cancer, first, the spino-celled cancers; second, the baso-celled cancers; third, the adeno-

* Read before the Medical Society, February 10, 1915.

carcinomata; fourth, sarcomata; fifth, malignant pigmented moles; sixth, Paget's disease.

Spino-celled cancers arise from the prickle cells of the skin or mucous membranes. They are comparatively rare upon the face, with the exception of the lips, but the majority of carcinomata upon the trunk or limbs are of this nature. Unless removed within one month of their onset these neoplasms almost invariably metastasize to the regional lymphatics. Hence it is necessary to remove not only the growth itself, but also the glands. Clinically the growths may be either fungous or ulcerative.

The baso-celled tumors are commonest upon the face, especially around the eyelids and the naso-facial grooves. They arise from the basal layer of the skin or hair follicles and never metastasize. It is important to remember that in origin they may be multicentric, hence recurrence after operation is not unusual. These tumors may be either fungous or ulcerative. Inasmuch as they do not metastasize, local removal, if complete, will effect a permanent cure.

The adeno-carcinomata spring from either the sweat or sebaceous glands, and the question of metastasis has not as yet been thoroughly determined; it is probable that if operated upon early it is not necessary to do a complete operation, but that local removal would suffice.

Sarcomata may be multiple or single, and may vary widely in their pathology; they are apt to spring from fibrous growths of various kinds, especially from scars. As a general rule the spindle-celled growths do not metastasize early, so local removal at the first indication of trouble would usually cure. Later there is no advantage in doing more, inasmuch as metastases usually take place through the blood stream.

Malignant moles are the most deadly of all forms of neoplasms. When a mole goes bad it gives no warning, but metastases arise by the time that the initial change is noted in the mole. But one case has so far been cured. The only successful treatment is prophylaxis. Clinically there are usually numerous pigmented metastases to the skin and glands.

Paget's disease may occur either on the breast or elsewhere upon the skin. At first there is an eczematous looking patch, which appears more granular than an ordinary eczema and which refuses to heal. Such a patch has a perfectly typical pathological picture, and when this picture is found a radical operation should be performed at once.

The prophylaxis of cancer is important. In special, two common types of lesion should receive treatment, namely, senile keratoses, and pigmented moles that may be irritated. Both can be removed without leaving any noticeable scar. In addition, all wens and subcutaneous nodules should be removed. Long con-

tinued small x-ray treatments are bad for both the operator and patient. All forms of skin troubles should be healed as speedily as possible.

Once the cancer is established it must be removed locally; that goes without saying. There are various methods of removal, the knife, cautery, curette, caustic, x-ray, radium and electrolysis. But there are two things to consider; first, that the removal be complete, and secondly, that some of the tissue be preserved for examination. This latter is essential for two very different reasons; first, we need more definite information to correlate the clinical finding with the histological picture of varying types, and secondly, because in each individual case we should know whether we are dealing with a growth that is apt to metastasize, and if we are to remove the draining glands at once. This is just as important in cancer of the skin as in cancer of the breast.

Personally I feel that in the basal-celled growths either the knife or cautery should be employed except in tumors around the eye, ear or naso-facial groove where severe deformity might result, and where it is allowable to try the x-ray. The surgeons certainly have better statistics than have the dermatologists, and have followed their cases for a longer space of time. The x-ray is not more efficient than radium nor is it less so, but it should be given in one or two large measured doses.

In the prickle-celled growths the problem is identical with that of cancer of the breast or lip; the draining glands must be removed, preferably in a block operation, but removed at any rate.

Dr. Selby had enjoyed the paper very much. He wished to ask why Dr. Hazen held the opinion that prickle-cell epitheliomata are preferably not treated by x-ray, while basal-cell cancers may be?

Dr. Jack said that Dr. Hazen had stated that there is on record only one case of cure after metastasis from a pigmented mole. Dr. Jack had had one case in which a recurrence followed one month after the removal of such a mole; a second extensive operation was followed by recovery, with freedom from recurrence now over a period of eight years. He expressed the hope that Dr. Hazen would write a book on dermatology and give the dermatological treatment for skin cancer as surgical, and thus get rid of the archaic character of most text books on this subject.

Dr. Kober expressed his appreciation of the paper. In his opinion it was a demonstration of the wisdom of the American Medical Association in designating Dr. Hazen as chairman of the section devoted to the study of this subject. As to the frequency of this disease, Mr. Rittenhouse, the actuary of a New York life insurance company, was the first to call attention to the alarming increase in the prevalence of cancer and to the waste of life caused

by preventable cancer. We are certainly on the right track when this Society undertakes to study seriously the problems of the prevention and cure of this disease. Dr. Kober had always been chagrined by the fact that the American Association for the Prevention of Tuberculosis has had to conduct the warfare against that disease because of the tardiness of the profession to act; and he expressed the hope that no such situation would be allowed to arise in the case of cancer.

Dr. Groover asked Dr. Hazen what he thinks of the post-operative treatment of prickle-cell cancers by x-rays?

Dr. W. P. Carr said that Dr. Hazen had spoken of two points especially of very great importance. The first was that cutting into a cancer to obtain a section for examination, with subsequent operation, precludes a hope of cure. Dr. Carr agreed that the only thing permissible is to do an immediate frozen section, and even that in his opinion is dangerous. After incision for the extirpation of cancer, the use of bichloride solution freely on the sponges will prevent the absorption of cancer cells; he felt convinced that in this way one can get as safe results as with the cautery and with better cosmetic effect. There need be entertained no fear of danger from absorption. Another important point spoken of by Dr. Hazen was the futility of doing an incomplete operation; if the tumor is sufficiently suspicious to warrant operation at all, the operation should be radical enough to meet the surgical requirements for a known cancerous tumor of the same character.

Dr. Hazen said that it should be insisted upon that no curative agent should be employed on skin tumors which prohibits a microscopic examination of the affected tissues; we are unable to tell the true nature of any skin neoplasm without microscopic study. The treatment must be different for prickle-cell and basal-cell epitheliomata because of the greater tendency of the former variety to metastasize. The x-ray will cure the local growth in prickle-cell cancer just as well as in basal-cell tumors; but it will not cure glandular metastases. However, even in basal-cell cancer the x-ray should not take the place of surgery. It must be remembered, moreover, that the x-ray burns may themselves cause cancer. He expressed the belief that there is a great future for the post-operative treatment of cancer patients with the x-ray, particularly in cancer of the breast. The introduction of the Coolidge tube adds to the brilliancy of that future.

Function of the Stomach.—The teacher was examining the class in physiology.

"Mary, can you tell us," she asked, "what is the function of the stomach?"

"The function of the stomach," the little girl answered, "is to hold up the petticoat."—*Buffalo Express.*

A CASE OF PITUITARY DISEASE, SHOWING BOTH ACROMEGALY AND ADIPOSIS.*

By Tom A. Williams, M. D., C. M. (Edin.),

Washington, D. C.

A nurse, age 32, was referred to me by Drs. Roy Adams and Borden in August, 1914. She was in bed in a condition of extreme excitability, with a good deal of palpitation, tremor, pain in the neck and head, and a boring sensation in the eyes. She stated that she had been nursing until two weeks before, and she had previously had periodical breakdowns about every few months without apparent cause. She had had these for about ten years, and had been under the care of Dr. Thayer since Dr. Osler left Johns Hopkins. The belief was that her case was one of hypothyroidism. Dr. Osler's opinion had induced her physicians to give her 15 grains of thyroid gland per day.

Examination showed a pulse of 116, much fine tremor as well as jerkiness of movements and of the content of speech also, emotivity and great restlessness. The reflexes were brisk, blood pressure 153, diastolic 115; the heart sounds were over hard; there was slight exophthalmus. Further history showed that she had been very constipated; had been operated on by Dr. I. S. Stone for enteroptosis. She took phenolphthalein regularly. Usually she slept well. Her diet was too nitrogenous, and she took too much tea and coffee. The preliminary diagnosis was hyperthyroidism from medication, along with arterial hypertension.

She was treated by a low protein plus fruit diet, bromide of sodium and tepid baths and massage. In six days the blood pressure was 142 and 100, and in eleven days 120 and 90, and she felt quite well, the headaches having disappeared. By this time I was of opinion, on account of the marked tenderness on pressure, that the thickness of the subcutaneous tissues was not that of myxoedema, and might be due to dyspituitarism. This opinion was confirmed by questions which showed that her jaw had become more prominent and the hands and feet had increased, the latter by one and a half sizes. Pituitary substance, 15 grains per day, was prescribed pending further investigation. Blood pressure increased to 150 and 110, and she had attacks of weakness. Pituitary substance was then reduced to five grains a day; blood pressure then fell to 110 and 60, and she again felt quite well. Constipation, much to her surprise, was completely removed without any drugs whatever, in consequence of the properly-adjusted dietary, which I have elsewhere described.

Examination of the visual fields by Dr. W. A. Davis showed

* Reported to the Medical Society, December 16, 1914.

inversion of the colors and a flattening restriction and irregularity of both fields; but there were no scotomata. This confirmed the suspicion that there was hyperplasia near the *sella turcica*. Accordingly the x-rays were applied by Dr. Groover, six times in all, by the method of Béclerc. This for a while increased the excitement; so the pituitary substance was stopped. Later this was resumed, and the patient has since then been well on the whole, although she occasionally has a day when she is very much fatigued. These exacerbations are not dissimilar to those so graphically described by Dr. Mark in his own case. I quote from his book.

"*The Acromegalic State.*—I apply this term to the very strange condition which I so frequently lapse into, one which varies greatly in its degrees, when very slight, being nothing more than a mere uncomfortable feeling or 'malaise,' but in its severer form causing me to feel very ill, and perhaps for a while quite incapacitated. There are days when perhaps for about half an hour I feel 'a bit acromegalic,' most likely during the latter part of the morning, always my worst time. There are my 'bad days' when I am under the influence of this state from morning till night. For many years I have not passed a whole day quite free from this peculiar affection.

"*Symptoms.*—A general feeling of discomfort, sometimes with intense fatigue. A sensation akin to that of being partially under the influence of an anesthetic or some drug. Sometimes a feeling of restlessness or impatience, with perhaps a craving for food. Most frequently the desire to keep absolutely still. Intolerance of any noise or din. Intolerance of any strong light, of the glare of the sun reflected off the pavement when out of doors, of the light reflected from a white tablecloth, or from the forks and spoons lying on the dinner table. A feeling of giddiness, especially if walking in the streets, most troublesome when going around a corner, and the fear of being knocked over by any passer-by. Any physical exertion, like going up one or two flights of stairs, brings on shortness of breath. Afterwards the breathing is irregular, of a sighing character (? a sort of Cheyne-Stokes respiration). When I am at my worst I still seem to be master of all my mental faculties, but lose the inclination to make the best use of them. There is some mental depression, but it is over-balanced by the strong feeling that if I can only remain perfectly still for a little while the condition will pass off and I shall be all right. The desire to retire into my own den may be intense. *Ruat Coelum!* but leave me alone in my armchair! It seems as if all one's natural zest were gone. All interest in what is going on around one, or in what is going to happen, is lost for the time being. I am aware that when I am in this state certain physical changes take place in me which are quite obvious. Some of them have been noticed by my friends. My face is very

pale. My lower lip is much more prominent and drooping. This is the most characteristic sign. Often there is ptosis of the left eyelid. This has at times caused me to be thought asleep by anyone who happened to be that side of me. Eyes more sunken. The eyelids puffy and red. Tears flow so abundantly that I may have to mop my face with a handkerchief every few minutes. My hands become larger, especially broader. They are cold and moist. My feet also become swollen, so that my boots seem too tight. They perspire and soon become cold, often necessitating a change of socks later on. I assume more decidedly the acromegalic facies. How much this varies with me has often been observed and remarked upon by my medical friends. On some occasions I may be out walking in the streets, or in places where people congregate, when the fit is on, making me look and feel more acromegalic. And then, should a group of young women pass by, and should they be of that age when maids are wont to giggle, I become aware that their brains contain a center capable of being stimulated by something in my appearance. This state always comes over me quite imperceptibly and leaves me in the same way. It is intimately connected with headache and faceache, and may be present with either one of them or both. I have suffered from this trouble in the most acute form when I have been traveling. It would come on after a long carriage drive, or when I have been much exposed to the cold.

"I have sometimes noticed that I feel unusually well during very foggy weather. My only means of getting comfortable again after a collapse is to have a good hour's sleep. One's mental capacities are affected ; they become depressed by the helplessness and the desire to avoid any effort, mental or physical. But even when the state is very bad one can master it by any very strong desire or emotion. At first the feeling was but a slight discomfort, or funny feeling in the head, which I connected with neuralgia, but later on it grew gradually into this acromegalic state."

The chief signs of pituitary disorder are as follows. Those presented by this patient are marked by an asterisk :

Neighborhood Signs.—* Headaches and depressions, photophobia, sella turcica changes, * hyperplastic changes, * visual disturbances, superior temporal hemianopsia, pupillary and ocular motor signs, anosmia, * neuralgia, spasticity. uncinate signs, naso-pharyngeal, epistaxis, intermittent catarrh, adenoids, cerebrospinal rhinorrhoea.

Glandular Signs.—* Skeletal overgrowth, * jaw, * fingers, radial epiphyses, skeletal undergrowth, feminism, genu valgum, pelvis latum, taper fingers, persistent epiphyses, * maxillary prognathism, cutaneous changes, * hypertrophic, coarse skin, secretory glands, * dense tissue, hypertrichosis, transparent dry smooth skin, arteriosclerosis, uncrescent nails, pigmentation, * adiposity, nanism, * adiposis dolorosa.

Carbohydrate Tolerance, Hyper or Hypo.—Polyuria, temperature changes, * blood pressure signs, hypersomnia, * insomnia, psychic disturbances, *a.* compressure distortion, * irritability or wakefulness, indecision, * lack of concentration, *b.* glandular, * amnesia, torpor, epilepsy.

Endocrinian Signs.—* Gonad, *f.* dysthyroidia, ? dysadrenia, persistent thymus, relation of pineal.

Incidence.—Inheritance, physiological epochs, hibernation, pregnancy, infection, vascular disturbances.

General Pressure Signs.—Papilloedema, palpebral and scalp venous stasis, osteoporosis around arachnoid herniae.

This case is difficult of complete interpretation ; but it would seem that, as is sometimes the case with the thyroid gland, there are alternations in the functions of the pituitary body ; sometimes the secretion of the anterior lobe is interfered with by the pressure of the hyperplasia which exists, giving rise to the tender adiposis and a great asthenia ; at other times the new growth seems to stimulate the action of the pituitary gland, giving rise to a high blood pressure, the excitement and perhaps the headaches and general discomfort, as well as, of course, to the gradual enlargement of the skeleton and its distal points, more especially the inferior maxilla. Regarded as an acromegaly the case is a very mild one, as there is no spacing of the teeth nor marked thickening of the metacarpal bones ; from the point of view of intracranial neoplasm, the condition is also mild, the only decided sign being the inversion of the visual fields. It is too early yet to prognose definitively, as we do not know the nature of the growth, nor do we know whether the subsidence caused by the radiotherapy is permanent in these cases. The interest of the case, however, warrants its presentation during the course of its evolution. I hope to present the further history along with several other cases in the course of the year.

Dr. J. D. Morgan said that ten or eleven years ago while going through the wards at St. Elizabeth's Hospital his attention was attracted by a young woman about 20 years of age who had very prominent malar prominences and abnormally large hands and feet. He had at that time been attending Sir William Osler's clinics at the Johns Hopkins, and the teachings there received concerning diseases of the ductless glands, including those of the pituitary body, had made such an impression upon him that he had had no difficulty in recognizing in this young woman the symptoms of acromegaly. Pituitary extract was given to this patient for a period of about three months, without result. He mentioned this case to show that even if Dr. Osler had not diagnosed acromegaly in Dr. Williams' case, he could at any rate teach others to recognize the disease very easily.

Dr. Roy said that Dr. Williams had alluded to the high blood pressure and had stated that this condition might be due to the thyroid extract that had been given ; on the other hand, might it not be due to oversecretion of the posterior lobe of the pituitary gland ?

Dr. Stavely had had only recently in his office a woman who gave a history of interest in connection with the topic under discussion. This woman had had an operation for disease of the ethmoid cells ; afterward she became subject to some sort of curious fits with alarming symptoms, and for this condition consulted Dr. Cushing, who suggested that they might be due to some injury to the pituitary gland received during the ethmoidal disease. The exhibition of pituitary extract caused inhibition of the symptoms.

Dr. O'Malley said that the patient referred to by Dr. Morgan is still an inmate at the Government Hospital for the Insane ; her acromegalic symptoms are and have been stationary.

Dr. Williams was not prepared to say that the high pressure in this case was actually due to the taking of thyroid extract ; it might have been due to other causes. Dr. Stavely's case was very interesting and opens a wide field for speculation ; he had himself a case in which it had been suggested that some symptoms of dyspituitrism might be caused by sphenoidal infection. He had had a number of cases of hypopituitrism, all of which had been amenable to treatment. As to Dr. Morgan's remarks, it is easy to make a diagnosis of this condition in marked cases. But in mild early cases it is not easy to recognize ; and unless one happens to have the condition in mind it is very easy to overlook the significance of the symptoms. He had not said that Dr. Osler couldn't diagnose this disease ; he merely said that he didn't diagnose this case. Most likely at the time Dr. Osler saw the case it was not diagnosable.

A Good Catch.—The old physician is an enthusiastic angler in every sense of the term. While on his way home from a fishing trip, he received an emergency call. The proud, newly-made father was impatient to have the child weighed, but couldn't find the steelyards ; so the physician had to use the pocket scales with which he weighed his fish.

"Great Scott, Doctor !" exclaimed the father as he saw the pointer go up. "Thirty-seven and a half pounds !"

—*Everybody's.*

MEMORIAL MEETING, JANUARY 20, 1915, IN HONOR OF THE LATE DR. A. F. A. KING.

Report of Committee on Memorial, Prepared by Dr. D. S. Lamb.

Whereas, Doctor Albert Freeman Africanus King, a member of this Society from July 4, 1864, over fifty years ago, a native of England but American by adoption, died suddenly December 13, 1914, at his residence in this city, in his seventy-fourth year;

Be it Resolved, That the death of Dr. King removes from our midst one of our oldest, most faithful and most useful members. When in the city he was rarely absent from our meetings. He was greatly interested in both the business and the scientific work of the Society. He made frequent, timely and useful suggestions and motions toward the satisfactory transaction of business. He is best remembered, however, for his part in the scientific work of the Society. His part was unique, in that while he read many papers and on a variety of subjects, none of them were mere compilations or commonplace, but were characterized by rare and original thought. The first that he read before the Society was May 30, 1864, on the trite subject of "Menstruation," but he took the ground that it was *a disease.* From that time he repeatedly surprised us by brilliant theories of the etiology of disease.

He served the Society in many capacities. He was Recording Secretary in 1865–68, and, much to his credit, made an excellent index to the transactions of the Society from 1838 to 1866. He was a member of the Board of Examiners for five years, the Board which expired by limitation in 1896 when the present law was passed in regard to the registration of physicians in this District. He was Librarian in 1870–1, Vice President in 1877 and again in 1880, and President in 1883. He served on many committees; he was a member of the Committee on Microscopy in 1876, and the Committee on Publication from 1873 to 1878, and was a warm supporter of the proposition that the Society publish its transactions.

At the dedication of the Medical Hall at Tenth and F Streets Northwest, January 29, 1869, he was one of the speakers, and his interest in having the Society acquire a permanent home, instead of moving from one place to another, induced him to make the unsuccessful effort of 1911.

He made a memorial address to Dr. D. W. Prentiss at the meeting November 22, 1899; he wrote the biographical sketch of Dr. W. W. Johnston, for the memorial meeting March 24, 1902, and for Dr. Walter Reed for the Reed memorial meeting December 31, 1902. He also spoke on the subject of "Dr. Smith as

an obstetrician," at the memorial meeting to Dr. Thomas C. Smith, October 22, 1913. He read an original poem at the dinner given by members of the Society to Dr. J. Ford Thompson, March 7, 1907. A complimentary smoker was given to Dr. King himself, January 21, 1911, by members of the Society; he had then rounded out his seventieth year, and had been in practice over fifty years.

Resolved further, That as a member of this Society it may be said of Dr. King that he was a man of good judgment, a ready debater, he knew his subject well or frankly acknowledged his want of knowledge, was always good natured and courteous, and appreciative of the good work done by others. We honor his memory: Life after all is but a short summer and Death, it has been said, loves a shining mark. Peace to his ashes.

Resolved, That a copy of these resolutions be transmitted to his family.

(Signed)
Sterling Ruffin, *Chairman.*
Henry D. Fry.
Charles W. Richardson.
John Van Rensselaer.
A. R. Shands.
D. S. Lamb.

Albert Freeman Africanus King, by Dr. Henry D. Fry.

The subject of this biographical sketch was born in Oxfordshire, England, January 18, 1841. He died at his home in Washington, December 13, 1914.

His parents were Dr. Edward K. and Louisa Freeman King.

Dr. King's father became interested in the betterment of the poor of England, and he was actively engaged in a colonization scheme in Africa. His sympathy in that movement prompted him to name one of his sons Albert Freeman "Africanus" King. Mrs. King has in her possession a piece of silver with the following inscription: "Presented to Edward King, by the Members of the Tropical Emigration Society as a Mark of his Disinterested Kindness and Universal Exertions for the Welfare and Success of the Society."

Dr. Edward K. King subsequently turned his attention to colonization in America and brought over immigrants who settled in Virginia, descendants of whom are living there today. A. F. A. King attended school in Bichester, near Oxford, from 1848 to 1851. At the latter date, when he was ten years of age, his father again came to America, this time settling here with his family, which consisted of himself, his two sons and one daugh-

ter. They resided in Alexandria for several months before purchasing and removing to a plantation near Warrenton, Va.

Dr. E. K. King and his daughter are buried in Alexandria. The only surviving member of the family, Dr. Claudius E. R. King, is practicing medicine at San Antonio, Texas.

We next trace A. F. A. King to Washington, where he studied medicine under the tutelage of Dr. R. K. Stone. He was graduated at the age of twenty from the National Medical College (now the George Washington University).

His brother, Dr. C. E. R. King, is authority for the statement that during the years of his student life A. F. A. King was very temperate in his habits, quiet and reserved, studious, of an inquiring mind, and was a close observer. He first practiced his profession at Haymarket, Va., and on the breaking out of the Civil War he rendered service to the Confederate wounded after the battle of Bull Run. Dr. King later came to Washington and served as Acting Assistant Surgeon at the Lincoln Hospital, the site of which is now the Park of that name on Capitol Hill.

Dr. King attended medical lectures at the University of Pennsylvania, and was graduated from that institution in 1865. He came to Washington to reside and was present at Ford's Theater on the night that Abraham Lincoln was shot. Dr. King was seated in the orchestra near the President's box, and during the commotion that followed the fatal shot he climbed over the footlights and made his way to the box, rendering first aid and helping to carry the wounded President across the street to the house in which he died. Dr. King was one of the medical attendants until the sad end.

For some years, and until his death, Dr. King was Professor of Obstetrics in the Medical Departments of the George Washington University and the University of Vermont. He received the honorary degrees of A. M. (1884) and LL. D. (1904) from the University of Vermont. He was Dean of the Medical Department of the Columbian College (now George Washington University) from 1879 to 1894, and when the Medical Department of the Institution passed through a critical period of its existence, it was owing to his devotion and untiring interests that it came at last safely through the stormy passage into smooth waters.

Dr. King joined the Medical Society of the District of Columbia in 1864. At the time of his death, he was the third oldest surviving member. He was its Secretary in 1865–66–67–68, and its President in 1883. To the volume of the Transactions of the Society, covering the years from January, 1838, to October, 1866, he prepared an excellent index. He was President of the Washington Obstetrical and Gynecological Society 1885–86–87. His membership in the American Gynecological Society dated from

1886. Other medical societies of which he was a member are: The American Medical Association, British Gynecological, and Royal Society of Medicine. He was also a member of the following scientific societies: The Washington Academy of Sciences, The American Association for the Advancement of Science, the Anthropological and Biological Societies of Washington, and the Philosophical Society of Great Britain. He was Visiting Obstetrician to the George Washington University Hospital, and Consulting Physician to the Children's and the Episcopal Eye, Ear and Throat Hospitals. He was elected a Fellow of the American College of Surgeons in 1913.

Dr. King was an interesting and forceful speaker, combining originality with urbanity. In the conflict of debate he never lost that sense of good humor which always characterized him. His lovable nature won him hosts of friends; he had no enemies. He made many valuable contributions to medical and scientific societies. An essayist has been assigned to speak of these tonight, but I will intrude upon that ground only to mention one work which is intimately identified with Dr. King's medical career. King's Manual of Obstetrics first appeared thirty-two years ago, and with successive editions established a wide reputation of its author as a clear, forceful writer and an obstetrician of marked ability. A recent communication from his publishers says in part: "Dr. King was one of our oldest and most highly respected authors, and it has been our privilege to enjoy relations of author and publisher for over thirty-two years. The first edition of his Manual of Obstetrics appeared on May 18th, 1882, and successive editions were published at frequent intervals, the 11th, which is still current, being issued on September 2d, 1910. In this long and successful career the book has grown from a small volume of 331 pages, with 59 illustrations, to its present substantial size of 713 pages, with 341 illustrations and 3 plates. It has been very widely used both by students and practitioners of medicine. Dr. King was a man of great literary ability and gave to his work the important advantages of clear expression and a charming style. To this, no doubt, was largely due its great popularity."

Dr. King married Ellen A. Dexter of Boston, October 17, 1894. His widow survives him, as do also a son and two daughters.

"The days of our age are three-score years and ten; and though men be so strong that they come to four-score years, yet is their strength then but labor and sorrow; so soon passeth it away, and we are gone."

Dr. King had passed his three-score and ten, but he had not reached the period when his strength was labor and sorrow. A few days before he passed away he worked diligently and had nearly completed the revision of his Manual of Obstetrics, which

he was preparing for publication in the 12th edition. He also lectured to his classes on that day; his mind was bright, his thoughts lucid, physically he appeared the picture of health, and now he is gone. Let us remember him as we knew him—bright, cheerful and animated with a spirit which was contagious and left us better and happier for the influence of his life.

Dr. King as an Author, by Barton Cooke Hirst,* M. D., Philadelphia, Pa.

Nothing is so difficult in literature as an analysis on the part of a single individual of the qualities that make a writer successful in his appeal to many readers. To confine ourselves to medical literature and still further to limit the consideration to those books dealing with the subject with which Dr. King dealt, it would be a difficult, to me an impossible task, to catch the subtle qualities that establish a medical work firmly in the esteem of the medical public. There seems to be one essential to success. The book must reflect the man who writes it. He must have something to say and must say it in his own way. Take the successful books published in this country during the generation of which Dr. King was a part, written by men who were his colleagues, associates, personal friends. Goodell's work on gynecology comes to my mind as an example of what I mean. Perfect in literary style, a reflection of the general scholarship of its author, with a flavor of old world culture, a playful wit, an originality of expression, an appearance of spontaneity, which I happen to know was only accomplished most laboriously, it would be easier to my mind to explain its success during its writer's lifetime than to account for that of many of his colleagues. Lusk, I take it, owed the success of his book to his encyclopaedic theoretical knowledge, his clarity of expression and definiteness of opinion. Emmet, Skene, Thomas, Fordyce and Barker, each had a book familiar to every medical reader, as different one from the other as these men differed in personal character, mental traits and appearance, but each stamped with the reflection of its author, each in its own way, earnest, sincere and original.

It is needless to say that Dr. King's book has these qualities, or it would never have had ten editions nor have held its place so many years in American medical literature; but as in the case of his contemporary authors, there is much more that escapes critical analysis. One lays it down after a careful perusal with the feeling that it is good, that it fulfils its mission, that it repays a close attention. If I might venture to express my own opinion of the qualities that have given it a hold on medical students which has rarely been equalled I should say that, as in all read-

* Dr. Hirst was unable to be present because of a professional engagement in Philadelphia.

able books, one conceives a liking for the author and a wish to know something of his personality. It seems to me that any one must be impressed with the successful fulfilment of the promise made in the preface of a "brevity and simplicity of statement" for which every medical reader is grateful. It is strange that all medical authors do not strive to realize this ideal.

The late Dr. John Ashhurst, who was himself a master of concise and clear expression, told me that when the manuscript of his International System of Surgery was completed he found it exceeded the contemplated compass of the work by one-third. He reduced it to the desired size by asking each author to eliminate every unnecessary word.

Another merit that impresses me in Dr. King's book is the firm conviction and earnestness with which he wrote. The bountiful use of italics, gives to his written word the emphasis and impressiveness, as far as possible, of the spoken word. To one who like myself had the pleasure of an acquaintance with Dr. King and with his origin, some traits appeared in his writing that might have escaped the ordinary reader. His English birth and early training gave him the precision in the use of words and the larger vocabulary in which our English cousins, I think, excel us. Moreover, there also appeared between the lines the well-bred gentleman, the polished man of the world, that our departed friend really was.

Dr. King on Mosquitoes and Malaria, by L. O. Howard, M. D., Ph. D.

Much as I might wish to write of Doctor King as a personal friend, as a teacher, as a big, broad, warm-hearted human (and in all of these rôles I knew him well), and much as I should like to discuss the breadth of his scientific interests as shown by his activities in the Philosophical Society, the Biological Society, the Anthropological Society and the American Association for the Advancement of Science, it has seemed best to your committee that I should confine my consideration to the single episode in the career of this many-sided man which relates to mosquitoes and malaria.

Doctor King was a deep thinker. He was not satisfied with even the generally accepted and apparently well founded views of men of science and of his own profession without a careful consideration and an ingenious twisting and testing of argument. This quality of mind he showed in a marked degree during the years 1881 and 1882, when he was filled with the thoughts of malaria and its probable origin and transmission. He never told me how or when the idea came to him that mosquitoes were transmitters of this disease. His search of the literature prob-

ably followed a fairly well worked-out argument originating in his own mind. Surely he considered the idea as original when he came, probably late in 1881, to the laboratory of the late Dr. C. V. Riley, my former chief and predecessor in office, and talked over the idea with Riley and myself. Shame to the short-sightedness of the two of us, that we rather scouted the idea while giving him the information on mosquito biology which he afterwards incorporated in paragraph No. 1 of his published brief.

His argument was fully elaborated and his full paper was prepared early in 1882 and was read before the Philosophical Society of Washington, February 10 of that year, under the title "The Prevention of Malarial Disease Illustrating *inter alia* the Conservative Function of Ague." This meeting of the Philosophical Society was attended by forty-two members and visitors, and Doctor King's paper was discussed by Dr. J. S. Billings, Professor Doolittle, Doctor Toner and Doctor Antisell. No record was made of what was said in discussion except the following: "Mr. Billings remarked that since ague did not invariably result from insect bites, the most that could be claimed was that they accomplished an accidental inoculation with malarial poison."* This statement is rather ambiguous and does not indicate what Doctor Billings really thought of Doctor King's paper.

The paper in its full form was never published, but in the *Popular Science Monthly* for September, 1883, Vol. XXIII, pages 644–658, appears an article entitled "Insects and Disease —Mosquitoes and Malaria," which in a foot-note is said to have been an abstract of the Philosophical Society paper. It is upon this published abstract that the scientific world's knowledge of King's views is based. Since the discussion in Riley's office he had made a careful study of the literature and had found references to several early suggestions as to the possible carriage of disease by insects or as to the cause of disease by insect bites. His arguments are displayed in connection with nineteen propositions or series of facts with regard to the so-called malarial poison; these facts were derived from different sources, but most of them were quoted from a paper read by Dr. John T. Metcalf, United States Sanitary Commission, 1862. Not all of these nineteen paragraphs are of equal force, and it has become the custom of writers in referring to King's paper to reduce them practically to the following:

(1) The malarial season corresponds to the season of mosquito abundance.

(2) Malarial country is suitable for mosquito breeding.

(3) Similar conditions afford protection against malaria and against mosquitoes.

(4) Exposure to night air means exposure to mosquitoes.

* Bulletin of the Philosophical Society of Washington, Vol. VI (containing the minutes of the Society for the year 1883, etc.), published 1884, page 10.

(5) Influence of occupation. Soldiers, tramps and fishermen are particularly susceptible to malaria and are especially exposed to mosquitoes at night.

(6) Turning up the soil or making excavations in previously healthy districts is often followed by malaria, but this turning up of the soil gives opportunities for water to accumulate and thus for mosquitoes to breed.

(7) Coincidence of malaria and mosquito abundance—increase of both in late summer and early autumn.

But this summary gives but a faint idea of the value of the *Popular Science Monthly* paper. The reasoning throughout is close and convincing, and additional important points are brought out. For example, "'Malaria has an affinity for dense foliage, which has the power of accumulating it when lying in the course of winds blowing from malarious localities,' and mosquitoes accumulate in and are obstructed by forests and trees." Again, "'In proportion as countries previously malarious are cleared up and thickly settled, periodical fevers disappear.'" Here he points out that in such case the land is cultivated and its swamps and pools are drained, so that mosquito breeding places are abolished. He further states that as the forests and underbrush disappear before the implements of the agriculturist, colonies of mosquitoes wafted by winds are not obstructed and accumulated by foliage. Again, the fact that malaria usually keeps near the surface of the earth and is said to "hug the ground," or "love the ground," corresponds once more to the habits of mosquitoes.

It will be unnecessary to take up any of the further points, except to quote two significant paragraphs as follows:

"In opposition to the mosquital origin of malarial disease it is known that numerous mosquito wounds may be inflicted without the occurrence of malarial disease; but this is by no means incompatible with the theory. We do not yet know whether the poison be mosquital saliva, or whether the fever-producing element be a bacillus with which the puncturing proboscis of the insect may be loaded at the time of inflicting its wounds. The scratch of a lancet will not produce vaccinia, unless the instrument be charged with vaccine matter; the puncture-needles of Pasteur would be harmless and impotent, did he not load them with infecting bacteria; so with dog-bites and hydrophobia, etc.

Again: "Nay, it may even turn out that, under certain circumstances, mosquito-bites shall even be protective against malarial disease, for as Pasteur and others are able to produce, artificially, 'attenuated culture-fluids,' the inoculation of which, while producing slight symptoms, protects from more serious phases of disease, so may there exist in nature naturally 'attenuated' fever-poison fluids, the inoculation of which, by mosquital puncture, may produce trivial symptoms, and thus protect from more decided attacks of veritable fever."

In the first of these paragraphs Doctor King fully meets the objection which, curiously enough, is raised today in the Bitter Root Valley in Montana by the inhabitants who claim to disbelieve the so-called tick theory of the transmission of the Rocky Mountain spotted fever. "Why," they say, "we have been bitten by ticks many times and have never had the fever." As King pointed out in these early days, they have not been bitten by an infected tick.

In the second paragraph he almost anticipates Koch's conclusions as to the immunity of native children in German East Africa, even though he does not point out their danger as reservoirs.

It may be well to quote still another paragraph which is of especial significance:

"In so far, therefore, as regards the geographical relation between mosquitoes and malarial disease, it may be said: 1. The two often co-exist; 2. There is no decided proof that localities alleged to be exempt from ague are also exempt from mosquitoes; 3. There is no locality noted for malarial disease where mosquitoes do not exist."

Very naturally, in his conclusion, the far-sighted author mentions the question of prophylaxis on the basis of his theory. He points out protection to the individual during the evening and night by gauze curtains, window-screens, or clothing impenetrable to their probosces, or an anointment of the body with some liniment; protection to the domicile by screens of fences or light traps, or the use of smoke, such as Pyrethrum, or of a volatile oil; municipal protection by the draining of swamps and pools, etc.

It will thus be seen that malarial prophylaxis has made practically only one step since the days of King's papers, except in so far as measures are concerned which depend upon the now known biological peculiarities of malarial species. His system included everything which was done in Italy for many years after Ross' discovery and which resulted in the lowering of the percentage of malaria on the Roman Campagna from 74 to 14, and his only omission from the present system is that of quininization of the people at large as practiced by Koch in East Africa and by the late Doctor Celli and his colleagues in Italy.

It is strange that so suggestive a paper as this and in fact one so theoretically conclusive should have been received with so little interest and have been so soon forgotten. That Doctor King was a strong man is shown by the fact that he was not in the least discouraged by his interview with so renowned an entomologist as Riley, or by the lukewarm interest with which his original paper was received by the Philosophical Society of Washington, but went on and prepared it in its permanent form for publication in the *Popular Science Monthly*.

There was little published comment, and it was not until 1899, sixteen years later, that Dr. George H. F. Nuttall, now of Cambridge University, England, in his classical paper "On the Rôle of Insects, Arachnids and Myriapods as Carriers in the Spread of Bacterial and Parasitic Diseases of Man and Animals—A Critical and Historical Study," published as one of the Johns Hopkins Hospital Reports, Vol. VIII, Nos. 1 and 2, that the full force of King's argument began to be appreciated. Nuttall here incorporated practically all of King's arguments and added many data gathered from other writers, as well as his own, and, as he has since publicly stated and as he has personally remarked to me, it is remarkable that the 1883 paper was not soon followed by critical investigation. As has been shown so many times since, however, and strikingly in the case of Sambon's insistent claims for the carriage of pellagra by Simulium, a theory in no way comparing with King's for the soundness of its basis, conclusions based on epidemiological findings or upon coincidences are always dangerous. Where the range of a suspected host coincides with the range of a disease it is possible or even probable that the suspected host may have some relation to the disease; but of course transmission experiments are necessary for absolutely definite conclusions.

And so it happened that, apparently without knowledge of King's paper, but based upon his own work in the transmission of filariasis by Culex and upon the then recognized transmission of the causative organism of Texas fever of cattle (sometimes called bovine malaria) by a tick, as demonstrated by Smith and Kilbourne, Manson suggested to Ross the necessity for accurate laboratory work on malaria with mosquitoes as possible hosts. How triumphantly Ross carried out this magnificent piece of research is known to all the world, but it is a pity that it had not been done years earlier. Of course the laboratory technique in 1883 was not what it was in 1897, and of course, although Laveran had already discovered the *Plasmodium malariae,* practically nothing was known of its life-cycle in 1883; but is it not possible, indeed, is it not probable, that, had our fellow member, Doctor King, possessed the laboratory facilities and the technique at the time when he was so full of his great idea, he would have solved the problem, would have confirmed his anticipations, would ultimately have received the Nobel prize, and would have gone down to history as one of the greatest benefactors of the human race?

Dr. King as a Teacher, by Dr. Sterling Ruffin.

The career of A. F. A. King as a teacher began in his early manhood and lasted uninterruptedly until the end of his life. His last act before going to his death-bed was to meet his class at the

George Washington University on Thursday, December 10, 1914. At the conclusion of his lecture he was stricken with the illness which was soon to destroy him. There was a certain melancholy fitness about such a mode of exit, for his affection for his students, as so beautifully expressed in the dedication of his Manual of Obstetrics, was in part the inspiration of his professional life: "Designed in particular for my own students, to them this book is affectionately dedicated."

A review of the file of catalogues of the George Washington University shows a teaching record of a duration vouchsafed to comparatively few men, honorable to the highest degree, and splendidly fruitful of result.

In the catalogue of 1865–66 of Columbian College, the predecessor of Columbian University, which in turn became the George Washington University, the medical department of which was styled the "National Medical College," his name as a teacher first appears, with the title of lecturer on toxicology in the auxiliary course.

The catalogue for the following year carries his name as adjunct to the chair of materia medica and therapeutics, which chair was held by Dr. John C. Riley, who was also dean of the faculty.

The catalogue for 1867–68 does not carry Dr. King's name as a member of the faculty, but announces a course of lectures on new remedies by A. F. A. King, M. D., to be given in the spring and summer course beginning April 8, 1868.

The announcement for 1868–69 makes no reference to Dr. King, a circumstance doubtless due to the fact that there is no description of the courses offered and that the only names appearing in the catalogue are of those of professional rank and that of the demonstrator of anatomy.

In the catalogue for 1870–71 Dr. King's name appears as Assistant to the Chair of Obstetrics, which is the first evidence of his interest in that subject. The chair of obstetrics and diseases of women and children was held by Dr. William P. Johnston, whom, although dead since 1876, some of the oldest members of this Society will remember as the leading obstetrician of his day in this locality. What Dr. King's duties were as assistant to Dr. Johnston is not stated, but that his work was of a high order and that he had won the full confidence and esteem of the faculty and impressed them with his worth and ability as a teacher is abundantly witnessed by the fact that in 1871, upon the retirement of Dr. Johnston from active teaching, Dr. King, at the age of thirty years, became his successor as Professor of Obstetrics and Diseases of Women and Children, which position and title he held uninterruptedly until 1904. In the latter year gynecology and pediatrics, having during the several preceding years developed into distinct sciences and having become, in the nature of

things, disassociated from obstetrics, so much of his title as related to diseases of women and children was dropped. He remained Professor of Obstetrics until his death, having, therefore, taught that branch of medicine in his alma mater continuously for a period of forty-three years.

In the year of Dr. King's promotion to the professorship of obstetrics in Columbian College, the faculty consisted, besides himself, of John C. Riley, N. S. Lincoln, J. Ford Thompson, W. W. Johnston, E. T. Fristoe and William B. Drinkard, all now dead save Dr. Thompson. The medical school was housed in the old building donated by Mr. W. W. Corcoran, which stood on the site of the present George Washington University Medical School building, and the total number of medical students in the school was forty-four.

The catalogue for 1872–73, under the heading of Obstetrics and Diseases of Women and Children, contains the following announcement:

"The course on this important department of medical science will comprise a series of sixty didactic lectures, fully illustrated by an elaborate collection of more than life-sized diagrams, manikins, models, and wet anatomical preparations. The various obstetrical instruments, as well as those employed in the treatment of uterine diseases, will be exhibited to the class, and their uses fully explained. The professor will endeavor to provide cases of midwifery whenever practicable, but these will be given out only to advanced students or candidates for graduation. During the latter part of the term special attention will be given to the diseases of women, with a view to render the student familiar with the various modes of manual and instrumental examination, and the surgical and therapeutical remedies required in the management of uterine diseases. For imparting to the student a practical knowledge of the subject it is hoped this course of instruction will compare favorably with that of any other college in the United States."

Dr. King's earliest lectures must have caused enthusiastic interest among his students, for of the ten graduates in the class of 1873, four read theses, in accordance with the then custom, on obstetrical or gynecological subjects, viz: one on multiple pregnancy, another on ergot, another on abortion and another on menstruation.

In 1871, the year in which Dr. King became Professor of Obstetrics, etc., in Columbian College, he was also elected to the same chair in the University of Vermont, and the tenure of the two positions was parallel, both terminating only at his death after forty-three years of faithful and continuous service.

How Dr. King became interested in the subject of obstetrics is not known. More likely than not it was through the influence

of Dr. William P. Johnston, whose assistant he was; and more likely than not it was largely through Dr. Johnston's influence that Dr. King became his successor. Dr. King was not elected to the chair of obstetrics in either university by virtue of any great achievement in research or otherwise, for at the time he had made no notable contribution. He must have been chosen on faith—faith on the part of the members of the two faculties not in what he had done but in what he would do—and the soundness of their judgment is evidenced by his subsequent achievements, his brilliancy as a lecturer and his contributions to the literature. His book was not a stepping-stone to scholastic position; on the contrary, making its appearance a little more than ten years after the commencement of his teaching career, it was the child of his ripening experience and maturing judgment as a teacher.

Dr. King was connected with many hospitals as attending or consulting physician at one time or another, Providence, Children's, Columbia, Episcopal Eye, Ear and Throat and the George Washington University, but so far as I know he did little or no clinical teaching, although in the catalogue for 1873–74 and those for several succeeding years it was announced that clinical lectures would be delivered in the medical and surgical wards of Providence Hospital by Professors J. C. Riley, J. Ford Thompson and A. F. A. King, who composed a part of the attending staff of the institution.

Dr. King was keenly alive to the value of clinical instruction in his as in the other branches of medicine, and if he had been forced to a choice as between didactic and clinical methods doubtless he would have chosen for his students the latter; but also he was firm in the conviction that the best rounded man is he who is most thoroughly drilled theoretically as a preliminary to clinical work; and he was in accord with those who believe that a method of teaching better than either the didactic or clinical is a combination of the two methods. To the didactic teaching of obstetrics he devoted his life as a teacher, content to leave the clinical side to those to whom it appealed more strongly, and happy in the knowledge that he was rendering to his students a service which would be to them a great and lasting benefit.

As a lecturer Dr. King was easily the peer of any man to whom I have ever listened. His lectures were masterful. They were so embellished as to be of absorbing interest, yet, as to statement of fact and elaboration and explanation of theory, were models of conciseness and simplicity, tremendously impressive and effective. He had the power of persuading and impressing his hearers to an eminent degree. No student ever left his class-room without feeling that he was carrying away something worth while and the realization of having sat at the feet of a master. I remember well how during my student days many of us had no book on obstetrics—some of us because we were too poor; others

of us because Dr. King's lectures made his subject so simple and easy that a book was not considered essential—a very genuine tribute to his masterful gift as a teacher. Even in his latest years he retained a boyish fire and enthusiasm.

Dr. King's fertility and originality of intellect were the admiration of his students as they were of the members of this Society. With respect to many subjects, obstetrical and otherwise, he had most ingenious theories. His theory as to the causation of cancer is very remarkable for its fertility of conception. In 1913 I had the pleasure of spending two days with him at his summer home at York Harbor, Maine. While there he remarked to me during the course of a walk that he had been trying for many years to kill an eagle. Upon inquiry as to why he specially wished to kill an eagle, he replied that the eagle's great acuity of vision had suggested to him that a study of the lens from an eagle's eye might lead him to the discovery of some improvement in the manufacture of microscopic lenses. This little incident, trifling enough in itself, so impressed me because of its originality and because of being so characteristic of Dr. King that, notwithstanding the complete absence of legitimate connection between it and the subject of this short paper, I wish here to record it.

Dr. King's professional fame rests essentially upon two things, (1) his splendid record as a didactic teacher of obstetrics and (2) his writings; and these may be said to share honors equally; either of them alone is abundantly sufficient to command the respect and admiration of this generation and of generations to come.

As Dr. King loved his students and spent a large part of his long life in laboring for their welfare and advancement, so his students loved him, and there is no medical alumnus of the George Washington University or its predecessors or of the University of Vermont, though his hair may have whitened with the passage of a near-half century since graduation, but who, upon learning of Dr. King's death, will bow his head in grief and reverence.

It was my sad privilege to be with Dr. King when he died and for several hours immediately preceding death. He died, as he had lived, a noble, courageous, lovable man.

> "A man resolved and steady to his trust,
> Inflexible to ill and obstinately just."

Dr. King as Dean of the Medical School, by Dr. D. K. Shute.

My first recollection of meeting Dr. King was in his capacity as Dean, when I went to his home, which was then at 726 Thirteenth Street, to register as a student in the National Medical College, the Medical Department of the Columbian University (now the George Washington University).

Apart from the general impression of a very pleasant and encouraging interview with the Doctor on this occasion, I have only a vivid recollection of one distinctly personal incident that occurred at that time, an incident which seemed to me then to be both novel and amusing. It pertained to signing my name on the registration list to complete the act of matriculation, and I ask your kind indulgence while I briefly relate it. My friends and companions and members of my family had always called me either Shute or Kerfoot; and nobody had ever called me by my first name, Daniel. Whenever friends or relatives wrote to me or whenever I wrote to anybody else, my name was always signed D. Kerfoot Shute. So Daniel seemed about as foreign to my personality at that time as would have Michael or Abraham. But Dr. King, in spite of my polite objections, insisted on my signing my name as Daniel K. Shute. He said that parting my name in the middle in the other way was just as bad taste as it would be to part my hair in the middle.

As a student in the Medical School I soon learned to have so great respect, admiration and affection for Dr. King, on account of his superb ability as a lecturer and teacher, and his charming personality as a gentleman, that I never forgot his contemptuous attitude towards parting the hair in the middle.

Probably it was my great admiration for Dr. King that prevented me ever parting my own hair in the middle to see what it would look like.

Later on in the passing years, after I had graduated from the Medical School, and had become a member of the Medical Faculty, mostly, I believe, through the selection and influence of Dr. King, I had occasion to observe his management of the office of Dean from two other interesting but distinct points of view, viz:

First, His management of the Deanship as Chief Executive Officer of the Faculty and as a broad minded Educator and,

Second, His annual provision for the Faculty Supper after the examinations were all completed and passed upon and just prior to the graduation exercises.

For many years the Columbian Medical School, like so many other medical schools throughout the country, was under the actual control of the Medical Faculty, not only educationally but also financially. Dr. King, in virtue of his position as Dean, was also virtual dictator, secretary and treasurer of the Medical School,—not dictator in any narrow and invidious sense, but dictator from the fact that his whole time, energy and thought were given up not only to the routine management of the school, but to plans for its improvement in the teaching personnel and equipment, and from the further fact that his colleagues ungrudgingly recognized his pre-eminent ability and scrupulous conscientiousness as a beneficent dictator and leader. His utmost endeavor was to always conduct the management of the school upon the

highest and most honorable plane possible, insisting strenuously upon his own methods unless convinced by the arguments of his colleagues that his own method was not the best. Doctor King was not only a Dean of strong convictions, but he had also that most admirable quality, the courage of his convictions.

As Dean it was his duty to see that all the students had paid all their dues before the college session closed; and he evidently had great talents here as in so many other directions, for, as he sometimes facetiously expressed it in the privacy of the faculty meetings, he generally milked the cow dry. This is one of the many directions in which Doctor King exhibited that personal magnetism which he possessed in so high a degree, for no matter how dry the cow was milked, the student body, collectively and individually, always had undoubted and enthusiastic admiration and respect for him, and always felt that he was a tower of strength and of prestige for the Medical College.

The annual faculty suppers were most delightfully informal affairs. Sometimes they were held at the old Willard Hotel, or at the old Shoreham, or at the Ebbitt House; but wherever held Doctor King was always the genuine host who took the greatest care to see that we all, collectively and individually, had a most enjoyable evening. The older members of the faculty made these occasions much more than a regal physical banquet, for in a most informal way, under the delicate stimulus of Dr. King, there were interesting and instructive discussions on philosophy, science, art, literature, travel, and many other topics, so that the banquet was in very truth a " feast of reason and a flow of spirit."

Dr. King was Dean of the Medical School for eighteen years, and although he resigned the position about seventeen years ago, he had conducted the office with such signal ability, upon so honorable, conscientious and dignified a basis, and with a mind single to the best educational interests of the students, that the recollection of his stewardship has always remained a potent influence for good in the Medical School.

Personal Characteristics of Dr. King, by Dr. A. R. Shands.

It has been well said that it is more interesting to the popular mind to dwell upon the deeds of military heroes or the history of men distinguished in the political arena than to follow the quiet career of one who has devoted himself unostentatiously to usefulness. We think more of him who consigns multitudes to destruction on the field of carnage than of the man whose office it is to save human life, and who by his discoveries, researches and instruction to others, has been and will be the means of saving from premature death still greater numbers. The first may

arouse our ambition, but the second should elevate us morally, and awaken in us a desire to be useful to our fellow man.

The sketch here offered is of a man who presents this contrast very strongly.

The above sentiment has been suggested to the writer by the last conversation he had with our dear friend, Dr. King, that occurred during a quiet hour spent with him in a cozy corner in the Cosmos Club just a few days before his death. At this time he seemed deeply impressed with the sad and heartrending conditions existing on account of the European War now raging, and expressed his feelings in no uncertain terms of what he considered the unnecessary and uncalled for wholesale destruction of human life. He truly believed in love and peace on earth and good will to men.

It is a well recognized fact that many of the most eminent men in our profession did not have the advantage of an extensive classical education. From this it would seem that strong intellects overcome these difficulties by arduous efforts. This was the case with our friend. The labor of mastering difficulties of a science like medicine is immensely increased by what would seem to be inadequate preparation, but his earnestness and zeal enabled him to overcome all difficulties and to attain the topmost rung of eminence in his special branch of medical science. He was earnest and zealous in every duty of life that he assumed, and these personal characteristics were nowhere more prominently shown than in his efforts to promote the best interest of the two Medical Schools, the George Washington University and the University of Vermont, with which he was connected for so many years.

Dr. King was one of the most regular attendants of our District Medical Society; he rarely missed a meeting and always took a prominent part in its affairs, which seemed always to give him the greatest pleasure, and before this Society he read many of his most scientific papers.

The acquaintance of the writer with Dr. King began twenty-one years ago this month, which was the very beginning of the writer's professional career in this city. This acquaintance soon ripened into the closest personal friendship, and the greatest admiration for his sterling qualities. He was a man endowed with brilliant qualities. He possessed a capacious intellect, well cultivated and replenished with literary stores; he was a wonderfully well read man, with a most retentive memory, gentle and refined to the highest degree; a gentleman of the old school, yet quite abreast of modern thought, a loyal Church-man, and by his courteous manners endearing himself to all who knew him. He was a loyal and unselfish friend. He was fluent and apt in discourse, with an excellent delivery. To these were added a ready

wit, generous spirit and joyous temper. These qualities were never better displayed than recently when seconding the nomination of the present President of this Society. This was his last speech in public, and it must be a source of great pleasure to our honorable President that Dr. King was spared to perform this act.

He was always keenly alive to the interest of all beginners in medicine, and always had a kind and encouraging word for them. Since his demise the writer has heard numerous young doctors speak of him in terms of greatest affection and admiration, and gratitude for help they had received from him in various ways, and especially for his kind words of encouragement.

It was in the qualities that constitute character that lay his strength. He recognized the great truth that men are born into this world for the performance of duties, and whoever neglects them lives in the violation of that law. He tasked himself to the highest to improve the faculties that God had given him. More than this is not in man's power.

From these feelings proceeded his assiduity, fixedness of purpose, concentration in what he engaged, his limitation to what he was capable of accomplishing, his order, method and truthfulness. What he did was done as a duty, as an end in itself, and not as means for popularity and fame.

Dr. King's life as a husband and father of a family was one of the happiest that it has ever been the good fortune of the writer to know. This short and imperfect sketch of the personal characteristics of our dear friend cannot be better brought to a close than by saying he was a model man, a model husband and a model father.

An Appreciation of Dr. King by a Former Pupil.—By Dr. E. Y. Davidson.

Mr. President and Members of the Medical Society:

I desire to speak a word of appreciation of Dr. King from the viewpoint of a former pupil.

Wherein lay the strong hold which Dr. King had upon his pupils? Was it due to his remarkable and exceptional powers of elucidation? However obstruse a subject may have been his genius so illumined it that it appeared elementary. Yet we must search further for the cause.

Was Dr. King's strong hold upon his pupils due to his matchless and incomparable delivery? None of us have forgotten and none of us will forget how, when emphatic, his arm moved in harmonious rythm with the music of his voice. Still we must search further for the cause.

Did Dr. King bind his pupils to him by his faultless diction? He could dip his brush in the varied hues of language, and at his touch the vault of heaven assumed a deeper blue and the lily farer grew. Still again we must search further for the cause.

When the Man of Nazareth walked upon the shores of the Sea of Galilee men were drawn to him, not alone by reason of the message which he brought to them, but also because of his humanity. When Dr. King walked among us his pupils were drawn to him not alone by reason of the message which he brought to them, but also because of that quality which elevates and dignifies and ennobles the man who possesses it. Dr. King ennobled himself and had the love and respect and veneration of his pupils because of his human touch, his human sympathy.

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In Memoriam.

DR. RALPH WALSH.

Ralph Walsh was born at The Mound, Harford County, Md., November 4, 1841, of distinguished parentage. His father, Hon. John C. Walsh, was for years State senator and a man of influence both socially and politically throughout the State. His mother, Amanda Lee Walsh, was of distinguished Quaker parentage and was noted for her personal beauty and charm.

Ralph Walsh received his early education at the Curtis Friends School of Harford County, after which he came to Washington, D. C., where he read medicine under Prof. Noble Young, who was for years professor of Theory and Practice of Medicine in Georgetown College, of which school Dr. Young was one of the four organizers. Dr. Walsh graduated in medicine in the spring of 1863 and shortly afterwards joined the Medical Corps, U. S. Army, as an Acting Assistant Surgeon, in which capacity he served at Gettysburg, Penna., from July 31, to September 10, 1863; at the Carver General Hospital, Washington, D. C., September 16 to October 21, 1863; at the U. S. Army Medical Museum, October 22, 1863, to March 25, 1864, and at Army Square General Hospital from May 17 to July 25, 1864.

In a personal letter from Dr. Walsh to Dr. D. S. Lamb, he (Dr. Walsh) says: " I may mention that during this period, 1863, I was also placed in immediate charge of the Army Medical Museum, then located on H Street, between 13th and 14th Streets, N. W. Said museum when I assumed charge consisted of two large rooms filled with empty cases, a back building in which was stored a number of dry and moist specimens in barrels and alcohol to be mounted by Mr. Schafhirt, who was employed

for that purpose. There was also a mass of written histories, numbered to correspond with the specimens. Under my supervision the specimens were mounted, numbered and placed in cases, and the histories condensed and recorded. In other words, I think I can make a just claim, though I have never heretofore done so, to have started the U. S. Army Medical Museum. I mention as a possibly interesting fact that most of the alcohol used in the preservation of moist specimens was procured by the distillation of contraband liquors seized at the Long Bridge. These liquors ran from beer and blackberry wine to straight alcohol and were packed in many peculiar vessels. Frequently women were arrested with belts under their skirts to which were attached tin sectional cases, holding from a quart to a gallon, and in a number of cases false breasts each holding a quart or more."*

While the Army Medical Museum was started in 1862, owing to the conditions prevailing at that time, it is more than probable that the condition of affairs was very unsettled and that little or nothing had been done to systematize what material had been collected prior to the time Dr. Walsh was assigned to duty there, October, 1863. He resigned from the army July 25, 1864, and located in that part of this city then known as the Island, now South Washington, where he engaged in private practice and was for some years Corporation Physician.

In 1873 he was made Professor of Physiology in Georgetown College and he moved to the northwest section of the city, where he enjoyed a large and lucrative practice until 1901, when he retired from active practice and organized the National Vaccine Company to which he devoted most of his time for several years, when he retired from business and returned to the home of his youth, The Mound, Harford County, Maryland, where he died after a short illness, January 15, 1915.

Dr. Walsh was always an earnest worker in all that pertained to the advancement of medicine. He was an active founder of the Emergency Hospital and of the Garfield Memorial Hospital and was for years a member of the staff of the latter. From 1880 to 1882 he was the owner and editor of a quarterly journal, *The Retrospect of American Medicine and Surgery*. He also compiled and edited Walsh's Ledger and Walsh's Physicians Case Book.

*The following information in regard to the early history of the Museum may be appended. The movement towards making the collection was begun in August, 1862, by Surgeon General Wm. A. Hammond. Dr. J. H. Brinton, Surgeon, U. S. Vols., was appointed Curator, and Dr. Wm. Moss, Assistant Surgeon, U. S. Vols., Assistant Curator. Dr. Moss compiled a catalogue January 1, 1863, which was published, and comprised 985 surgical and 156 medical specimens. Fred Schafhirt was preparator, later being assisted by his two sons. By August 24, 1863, nearly 3,500 specimens had been collected, and the Museum had outgrown its quarters (180, old number, Pennsylvania Avenue, between 17th and 18th Streets). In September the collection was removed to what was known as the Corcoran School building on H Street, between 13th and 14th (now 1325). There can be no doubt that during the five months that Dr. Walsh was on duty at the Museum he had plenty to do. So far as I know, none of the attachés of that time are now alive.—D. S. Lamb.

In 1876 he married Miss Jeanie Patterson, of Mississippi, daughter of William Lindsay Patterson, who was consul to Genoa, Italy, under the Buchanan administration. Dr. Walsh is survived by his widow, a daughter, Miss Jean L. Walsh, of Maryland, and a son, Dr. Ferdinand C. Walsh, of San Antonio, Texas, who is a member of this Society.

Dr. Walsh was an honorable gentleman, a true friend, exemplary in every relation of life, and worthy of that esteem and confidence so willingly extended to him by his fellow men.

Resolved, That the Medical Society of the District of Columbia deplores the death of Dr. Walsh, and herein expresses its regret at the loss of so valuable a member of the medical profession and so worthy a citizen.

Resolved, That a copy of the resolutions be forwarded to the family of Dr. Walsh and that these resolutions of respect be entered upon the records of the Society.

(Signed) A. Barnes Hooe,
C. R. Collins,
Edward Mason Parker,
C. W. Franzoni,
Committee.

The foregoing resolutions were unanimously adopted by the Medical Society of the District of Columbia at a meeting held February 24, 1915.

Report of Dr. C. W. Franzoni, Treasurer of the Medical Society, for 1914.

Receipts.

Entrance fees for 1914, $155.00; from assessments for 1897, $4.00; 1898, $4.00; 1912, $160.00; 1913, $660.00; 1914, $1,340.00; 1915, $4.00. Sale of History of Society, $10.00. From Associate Members, $34.00. From Medical Association, $2.00. Advertising in Medical Annals, $71.00. Subscription to Medical Annals, $2.00. Interest on bank deposit at 2 per cent., $10.06. Cash balance January 1, 1914, $652.30. Total, $3,108.36.

Expenditures.

Stipend, Recording Secretary, $200.00; expenses, Recording Secretary, $18.48; stipend, Treasurer, $200.00; expenses, Treasurer, $22.25; stipend, Corresponding Secretary, $200.00; expenses, Corresponding Secretary, $317.06; expenses, Executive Committee, $6.50; publishing Medical Annals, $873.64; expenses, Editor Medical Annals, $2.00; honorarium, Editor

MEDICAL ANNALS, $200.00 ; rent of hall and lantern, $166.00 ; miscellaneous, $63.70. Balance carried forward, $838.73. Total, $3,108.36.

Assets.—Cash on hand December 31, 1914, $838.73 ; furniture, iron safe, etc., estimated, $91.50 ; unpaid assessments for 1913, $144.00 ; 1914, $748.00 ; volumes of History of Medical Society, $420.00. Total assets, $2,242.23.

Liabilities.—Storage, estimated, $10.00.

Members dropped for n. p. d., 5 ; resignations, 8 ; deaths, 8.

Membership, Dec. 31, 1914, 578.

PROCEEDINGS OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Stated Meeting Wednesday, January 6, 1915.—The President, Dr. Frank Leech, presided. Dr. Leech, on taking the chair, made appropriate remarks.

The Treasurer, Dr. C. W. Franzoni, made his 42d annual report ; referred to Executive Committee. See page 112.

The following applications for membership were referred to the Committee of Censors: Active membership, Claude Carlisle Caylor, University of Virginia, 1910 ; Melville Benheim Fischer, Georgetown University, 1913 ; Robert Steele Irvine, Columbia University, 1914 ; John Lawson Norris, National University, 1897. For associate membership, John Atkinson Ferrell, Assistant Director General, International Health Commission ; Louis Anatole LaGarde, Colonel Medical Corps, U. S. A.; Louis Anatole LaGarde, Jr.; Matthew A. Reasoner, Captain Medical Corps, U. S. A.

The Executive Committee recommended that an honorarium of $200.00 be paid to the editor of the ANNALS, Dr. D. S. Lamb ; approved.

The following were elected active members : Robert B. Bacon, College Physicians and Surgeons, Baltimore, Md., 1893 ; Samuel L. Battles, George Washington University, 1906 ; Augustus C. Gray, same, 1912 ; Charles P. Healy, Georgetown University, 1908 ; Ralph M. LeComte, same, 1910 ; Patrick S. Madigan, same, 1912 ; Thomas Miller, Jr., George Washington, 1914 ; Lester Neuman, Georgetown, 1913 ; Francis J. Ready, same, 1913.

Dr. T. A. Williams, from the Committee on Belgian Relief, reported that he had not received as many instruments as he expected, and would like to have more ; permission granted to place notice to that effect on program cards.

The Chair announced the following committees: Censors, Drs. C. L. Waters, W. J. Reeves, A. F. Foye, Edmund Barry, H. M. Kaufman.

Committee on Program: Drs. A. L. Hunt, P. S. Roy, J. A. Talbott, H. H. Kerr, J. J. Kaveney.

Committee on Publication: Drs. D. S. Lamb, H. H. Donnally, E. Y. Davidson, J. D. Thomas, H. C. Macatee.

Committee on Public Instruction: Drs. L. B. T. Johnson, J. B. Nichols, W. M. Barton, L. Tayler-Jones, Louis Taylor.

Committee on Red Cross Medical Work: Drs. R. T. Holden, D. O. Leech, John Van Renssalaer, from the Executive Committee, and Frank Leech and H. C. Macatee, ex-officio.

An invitation was accepted to attend a meeting of the George Washington Medical Society to hear a paper by Dr. J. T. Gerahty, on Renal Functional Tests. Acknowledgments read from Surgeon General Braisted of the Navy, of a vote of thanks; from Department of Justice, of resolution of the Society in regard to indictment of Editor of *Southern California Practitioner*, and from Commissioners, D. C., of resolution of Society in regard to the milk supply.

Dr. A. B. Hooe, for the Committee on Reception and Entertainment of the Medical Society of Virginia, reported that the work of the committee was finished, and recommended that the small balance of money left be given to some worthy charity. Recommendation adopted.

The resignation of Dr. F. S. Nash was accepted.

A proposed amendment to the Constitution increasing the annual dues was lost.

The following amendment was made to the Constitution: Article VI, Section 5, substituting the word "three" for the word "two," increasing the compensation of the Recording Secretary.

The Executive Committee was instructed to communicate with the Board of Medical Supervisors of the District asking whether the Board was empowered to revoke the license of Dr. T. J. Kemp, and, if so, whether the Board would take such action.

The thanks of the Society were given to Drs. Holden and Davidson, retiring Vice Presidents.

Wednesday, January 13.—Dr. Leech presided; about 90 members present.

Appropriations were made, $17.69, for the office of the Corresponding Secretary, and $2.00 for the office of Treasurer.

The resignation of Dr. H. N. Sisco was accepted.

Letters from the Board of Medical Supervisors, D. C., in regard to Dr. Kemp, and from the Secretary of the A. M. A. regarding fees for services under the Workmen's Compensation Laws, were referred to the Executive Committee.

Dr. T. A. Williams presented a patient with spinal amyotrophic

and sensory symptoms mistaken for neuritis, with history of case and analysis of symptoms. Discussed by Drs. J. D. Thomas, A. B. Hooe and Williams. See page 65.

Dr. Prentiss Willson read a paper: "Rectal examinations in labor." Discussed by Drs. Moran, Bowen, G. B. Miller, I. S. Stone, T. C. Martin, Lochboehler, Paul Johnson, Kober, W. P. Carr and Willson.

Dr. S. R. Karpeles read a paper: "A plea for a cancer clinic." Discussed by Drs. Kober, Gannon, Lawn Thompson, Chappell and others. See page 73. The paper was referred to a committee: Drs. Karpeles, Hagner, Balloch, W. C. Borden, W. P. Carr, Vaughan, J. F. Mitchell, Sprigg, C. W. Richardson, Gannon and Abbe.

Wednesday, January 20.—Dr. Leech presided; about 95 members and others present. Memorial meeting to Dr. A. F. A. King.

The program comprised the report of the Memorial Committee, prepared by Dr. D. S. Lamb, and which was adopted; Biographical sketch of Dr. King by Dr. Fry; Dr. King and mosquitoes and malaria, by Dr. L. O. Howard; Dr. King as a teacher, by Dr. Sterling Ruffin; Dr. King as Dean of the Medical School, by Dr. Shute; Dr. King's personal characteristics, by Dr. Shands; and A brief appreciation of Dr. King by a former pupil, by Dr. E. Y. Davidson. Dr. B. C. Hirst, of Philadelphia, who was on the program for a paper on Dr. King as an author, was unavoidably absent. See page 89.

Wednesday, January 27.—President Leech presided; about 135 members present.

The death of Dr. Ralph Walsh was announced and a memorial committee was appointed, Drs. A. B. Hooe, Franzoni, E. M. Parker and Collins.

The Executive Committee reported that in reply to the inquiry of the Judicial Council A. M. A. as to fees under the Workingmen's Compensation Law, the Council be informed that there is no such law in this District.

The committee also recommended an honorarium of $100.00 for Dr. Franzoni. The report and recommendations were adopted.

A letter was received from the Secretary of the Washington Surgical Society transmitting the recent Presidential address by Dr. Balloch before that Society and asking that it be published in the ANNALS. So ordered.

Dr. A. B. Hooe called attention to the *Harrison* bill in regard to narcotics, and on his motion the Executive Committee was instructed to consider the matter and report at next meeting of the Society.

Dr. C. W. Richardson presented two patients illustrating the cure of disease of the frontal sinus. Discussed by Drs. Oscar Wilkinson, McKimmie, Dufour and Richardson. See page 78.

Drs. Julius Friedenwald and F. H. Baetjer, of Baltimore, Md., addressed the Society, on the *x-ray diagnosis of gastro-intestinal diseases*. Illustrated by lantern slides. Discussed by Drs. W. G. Morgan, Verbrycke, Selby, Friedenwald and Baetjer. A rising vote of thanks was given to the Baltimore physicians.

Wednesday, February 3.—President Leech presided; about 55 members present.

The Treasurer reported for January; receipts, $220.00; disbursements, $19.69.

Dr. G. W. Cook, from the Executive Committee, reported that the committee had been unable to secure definite instructions in regard to the duty of physicians under the Harrison *Narcotic* law; recommended that the law be printed in the ANNALS. The committee also recommended the adoption by the Society of the following letter in regard to the Judicial Council of the A. M. A.

"The Medical Society of the District of Columbia is of the opinion that differences arising within the constituent bodies of the American Medical Association, either between individual members or between component county societies, should be adjudicated by the constituent bodies themselves, this being in accordance with the right of local self-government. This Society, therefore, is opposed to enlarging the powers of the Judicial Council giving it appellate jurisdiction in such cases as proposed in the pending amendment to Sec. 4, Chapter VII of the By-Laws of the A. M. A., and so instructs its delegate."

The recommendations were adopted by the Society.

An appropriation was made of $117.07 to defray the cost of the January ANNALS. Also for expenses of Corresponding Secretary, $10.52, and for Treasurer, $3.00.

The Executive Committee was instructed to consider the advisability of the Society having a permanent committee on legislation. Also, to consider the following resolution offered by Dr. Heitmuller: "That a special committee of three or more members be appointed to appear before the Commissioners of the District of Columbia and the proper committees of Congress, and urge the appropriation of funds to enable the Health Office to make the biologic tests for the diagnosis and control of treatment of venereal diseases, under such regulations as Congress might deem proper. And that the committee be permitted to take any further action, not involving the expenditure of the funds of the Society, to bring about the purpose of the motion."

Dr. Karpeles, from the Committee on Cancer Clinic, reported as follows:

"REPORT OF THE SPECIAL CANCER CLINIC COMMITTEE.

"S. R. KARPELES, Chairman; F. R. HAGNER, E. A. BALLOCH, G. T. VAUGHAN, W. P. CARR, W. C. BORDEN, J. F. MITCHELL, W. M. SPRIGG, C. W. RICHARDSON, J. A. GANNON, TRUMAN ABBE.

"The committee believes that the establishment of systematic clinical presentations of cases of cancer with the intent to demonstrate to the members of the medical profession the methods of early diagnosis and the appropriate methods of treatment is feasible and will foster better and earlier diagnosis of cancer and will lead to the better control of this disease. Therefore the committee recommends the organization of such a course of demonstrations, to be called herein the Cancer Clinic.

"The committee believes that it is feasible to arrange for the meetings of such Cancer Clinic in each hospital in the city and to arrange with the staff of each hospital for the temporary care of the patients and the expediting of the clinic.

"The committee would advocate the demonstration of cancer cases by any and all members of the profession who care to present such cases, emphasizing the method of diagnosis applicable to their special line of work, and the methods of treatment, giving demonstrations of the methods, tests, agents, etc., as used. The chief object of the clinic being one of systematic education of the practitioners, the histories of the cases should be submitted to the committee for classification before the meetings of the clinic, and appropriate groups of cases presented at each meeting.

"The committee recommends the meeting of the Cancer Clinic on the fourth Thursday of each month at 8 P. M. The place of meeting to be each of the hospitals in turn. The invitations to be sent out under the auspices of the Medical Society of the District of Columbia to all the members of the profession, not only to the members of the Medical Society. We would have included in the list of those invited to these clinics all registered physicians in the District irrespective of the school represented, the race of the individual, or the sex.

"The committee would recommend that a special Cancer Committee be made a permanent part of the Medical Society.

"That the expenses of the announcements and other necessary expenses, subject to the approval of the Council of the Society, be paid by the District Society.

"That the reports of the cases be published in the ANNALS and reprints distributed to those practitioners interested who are not members of the Society.

"That requests for cases for demonstration be made through the ANNALS, according to a systematic program to be gotten up by the committee."

The Society ordered the report to be printed and to be discussed February 17.

Dr. C. A. Simpson reported a case of Sporotrichosis schenkii. Discussed by Drs. Prentiss, Stanley and Simpson. See page 62.

Dr. J. C. McGuire read a paper entitled, "Poisons and their antidotes." Discussed by Dr. Jack.

Wednesday, February 10.—President Leech presided; about 75 members present.

The Executive Committee reported that the accounts of the Treasurer had been audited and found correct and his books admirably kept.

An appropriation of $36.77 was made for printing and postage of Corresponding Secretary.

On motion of Dr. A. B. Hooe, Dr. D. S. Lamb was requested to deliver an address on the growth and progress of the Army Medical Museum and the Library of the Surgeon General's Office on the approaching 50th anniversary of his accession to office in the Museum.

Dr. Nichols resigned as delegate to the Midwinter Conference on Medical Legislation, Public Health and Education of the A. M. A., and Dr. L. B. T. Johnson was substituted.

Drs. R. A. Hooe and E. F. King reported cases of urethral calculus. Discussed by Drs. H. A. Fowler, Hooe and King.

Dr. E. F. King presented two *urethral calculi* that he regarded as being of especial interest in that they apparently were composed of oxalate of lime and, although smaller than a 22 sound, they lodged in the urethra. The patient from whom the smaller stone was removed had a congenital stricture just back of the fossa navicularis. The stone was pushed back so that the stricture could be cut and then was removed by alligator forceps. In the other patient the calculus was located at the peno-scrotal angle and could not be moved, so that it had to be cut down upon.

Dr. H. A. Fowler had witnessed Dr. Hooe's operation and had listened to the case report with much interest. One point was not mentioned by Dr. Hooe, namely, that the operation was a very pretty one. As to the etiology of urethral calculi, a study of the cases in the literature shows that the great majority of such stones are formed higher in the urinary tract and lodge secondarily in the urethra. A few are formed originally in the urethra; such stones are usually phosphatic in composition. Dr. Fowler had had one case, a report of which he had presented to this Society several years ago, in which the conclusion was reached that the stone was primary in the urethra; this conclusion was fostered by the history of the case and by the fact that a perineal trauma immediately antedated the beginning of symptoms. The man fell down an elevator shaft and sustained a fracture of the pelvis; some complication made perineal section necessary. Later, urinary symptoms arose and the man was

advised to have an operation; this he declined and returned to his home in the country, where for nine years he bore the misery caused by a urethral stone which finally Dr. Fowler removed and the patient recovered. [Other urethral stones, secondarily lodged in the urethra and removed in various ways, were exhibited.]

Dr. E. F. King, commenting on Dr. Hooe's case, asked if when the stone was shown by the cystoscope to be apparently in the bladder, might not that fact have indicated the lithotrite as the preferable method of attack?

Dr. Hooe expressed his pleasure in hearing the cases reported by Dr. King. Replying to the question, he thought in view of the infected bladder in this case that the lithotrite was not the best way to remove the stone; certainly in his own hands the section was a much safer procedure.

Dr. T. C. Martin reported a case of recto-sigmoidal polypus. Discussed by Drs. Balloch and Acker.

Dr. H. H. Hazen read a paper on "Cutaneous cancer;" illustrated by lantern slides. Discussed by Drs. Selby, Jack, Kober, Groover, Carr and Hazen. See page 80.

WASHINGTON MEDICAL ANNALS.

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Editorial.

History of the Medical Society of the District of Columbia.—Price $1.00, with 25 cents added if delivered in this city or sent by mail. Address Dr. C. W. Franzoni, 605 I Street, N. W. The books are in the custody of Dr. D. S. Lamb, at the Army Medical Museum.

The Washington Medical Annals, the official organ of the Medical Society of the District of Columbia, issued the first of January, March, May, July, September and November, will publish gratuitously such information of a medical, surgical and sanitary character, changes in personnel, &c., of hospitals, dis-

pensaries, medical schools, medical societies and other medical agencies, as would be useful and interesting to the members of the Society. Address the Chairman of the Committee on Publication, Dr. D. S. Lamb, 2114 Eighteenth St., N. W.

THE OTHER MEDICAL SOCIETIES OF THE DISTRICT OF COLUMBIA.

ALUMNI MEDICAL SOCIETY OF GEORGETOWN UNIVERSITY.—Active membership of 110; meets on the third Saturday of the month at the Medical School. Officers: W. M. Barton, President; Chas. I. Griffith, Recording Secretary; J. M. Moser, Corresponding Secretary; Ralph O'Connor, Treasurer.

CLINICAL SOCIETY.—Officers: F. L. Biscoe, President; W. J. Mallory, Vice President; E. P. Copeland, Secretary-Treasurer; Censors: L. A. Johnson and J. D. Thomas.

1915.	*Meeting Place.*	*Essayist.*	*Discussion by.*
April 12	Dr. T. A. Groover	Dr. J. D. Thomas	Dr. Hurt.
	Iroquois.		
May 10.	Banquet.		
October 12	Dr. J. D. Thomas	Dr. C. S. White	Dr. Reichelderfer.
November 9	Dr. E. P. Copeland	Dr. W. A. Wells	Dr. Richardson.

CLINICO-PATHOLOGICAL SOCIETY.—Active membership limited to 25. Inactive membership: those who have withdrawn from active membership after 15 years. A limited honorary membership of eminent medical men. Meets on the first and third Tuesdays of the month from October to May, inclusive. Officers: President, J. D. Thomas; Vice Presidents, Loren Johnson and H. P. Parker; Secretary and Treasurer, B. M. Randolph.

FREEDMEN'S HOSPITAL MEDICAL SOCIETY.—Meets on the second Wednesday of each month from October to May, inclusive. Composed of physicians connected with the Staff of the Hospital and the Medical Faculty of Howard Medical School. E. A. Balloch, President; S. L. Carson, Vice President; C. A. Allen, Secretary-Treasurer; Committee on Program, E. A. Balloch, S. L. Carson and H. H. Hazen.

GALEN SOCIETY of the District of Columbia.—Wm. H. Littlepage, President; Harry A. Ong, Secretary.

1915.	*Place.*	*Essayist.*
March 15	Dr. Mallory	Dr. Cox.
	1720 Connecticut Avenue.	
April 19.	Dr. Wilson	Dr. Copeland.
	2714 Ontario Road.	
May 17	Dr. Spire	Clinical.
	1609 North Capitol Street.	
October 18	Dr. Pfender	Business Meeting.
	304 Rhode Island Avenue, N. W.	President's Address.
November 15	Dr. Henning	Dr. Pfender.
	The Rochambeau.	
December 20	Dr. Titus	Clinical.
	1730 M Street, N. W.	

GEORGETOWN CLINICAL SOCIETY; twenty-five active members, limited to graduates of the Medical Department of Georgetown University. Meets at the University Club on the third Tuesday in the month. John Foote, President; J. Russell Verbrycke, Jr., Treasurer.

HIPPOCRATES SOCIETY, membership limited to 25, with voluntary retired members after 10 years, meets on the second Thursday of the month from October to May. Officers for the year: J. R. Verbrycke, Jr., President; C. A. Simpson, Secretary.

1915.	*Place.*	*Essayist.*
March 11	Dr. Syme	Dr. Brandenburg.
April 14	Dr. Henning	Dr. Simpson.
May 12	Dr. Moore	Dr. White.

MEDICAL HISTORY CLUB of Washington, D. C.—Officers: President, Philip Roy; Vice-President, F. H. Garrison; Secretary, John Foote; Executive Committee, I. S. Stone, H. W. Lawson, Wm. A. White and the Officers. Members: Truman Abbe, Frank Baker, W. C. Borden, Joseph H. Bryan, G. Wythe Cook, John Foote, F. H. Garrison, Howard Hume, H. W. Lawson, W. J. Mallory, G. Brown Miller, J. D. Morgan, John B. Nichols, P. S. Roy, I. S. Stone, John D. Thomas, Wm. A. White, W. W. Wilkinson, Mathew Kollig.

MEDICAL AND SURGICAL SOCIETY of the District of Columbia.—President, John Dunlop; Vice President, H. H. Hazen; Secretary and Treasurer, L. Eliot; Asst. Secretary, L. C. Ecker; Executive Council, O. A. M. McKimmie, E. L. Morgan, L. Eliot, L. H. Reichelderfer and Ecker.

SOCIETY OF MEDICAL JURISPRUDENCE, Washington, D. C. —President, Dr. Wm. A. White; Vice President, R. Ross Perry; Secretary-Treasurer, Dr. D. P. Hickling. Meets on the second Monday of each month from October to June at University Club. Has from forty to fifty members.

SOCIETY OF OPHTHALMOLOGISTS AND OTOLOGISTS, Washington, D. C., meets the third Friday of each month from October until May, inclusive.

Officers: President, L. S. Greene; Vice President, A. B. Bennett, Jr.; Secy.-Treasurer, A. H. Kimball, The Farragut.

Active members: Drs. A. B. Bennett, Jr., J. W. Burke, V. Dabney, W. T. Davis, L. S. Greene, C. Henning, E. B. Jones, A. H. Kimball, R. S. Lamb, F. B. Loring, O. A. M. McKimmie, W. B. Mason, M. E. Miller, Mead Moore, S. B. Muncaster, W. S. Newell, J. J. Richardson, E. G. Seibert, R. R. Walker, W. A. Wells.

Inactive members: Drs. J. H. Bryan, W. K. Butler, H. S. Dye, Wm. H. Fox, W. P. Malone, H. A. Polkinhorn, C. W. Richardson, D. K. Shute, W. H. Wilmer.

SOCIETY OF SOCIAL HYGIENE, Washington, D. C.—President, Surgeon General Stokes, U. S. Navy; Secretary, Lt. Col. J. R. Kean, U. S. Army, Surgeon General's Office. The Society has four committees, namely: Education, Venereal Diseases, Protection of Women and Children, and Psychopathology. Yearly dues, $1.00. Persons desiring to become members should address Col. Kean and state to which committee they wish to be assigned.

THERAPEUTIC SOCIETY of the District of Columbia.—Meets at the G. W. School of Pharmacy, 808 I Street, N. W., on the first Saturday in each month. G. W. Latimer, President; A. P. Tibbets, Secretary.

WALTER REED MEDICAL SOCIETY meets on the fourth Thursday of every other month, from September to May inclusive. Composed of physicians located in the eastern part of Washington. Officers: J. S. Arnold, President; H. R. Schreiber, Vice President; M. H. Prosperi, Secretary; N. E. Webb, Treasurer.

WASHINGTON MEDICAL AND SURGICAL SOCIETY.—President, Neil D. Graham; Vice President, R. R. Walker; Secretary, Walter Van Sweringen; Treasurer, Frank E. Gibson; Curator and Librarian, E. H. Egbert. Executive Committee: L. H. Taylor, Chairman; G. S. Clark, G. S. Barnhart. Program and Auditing Committee: Wm. A. Jack, Jr., Chairman; J. R. Nevitt, Walter Van Sweringen. Membership Committee: Frank E. Gibson, Chairman, Wm. P. Reeves, Caryl Burbank.

Program—1915.

Essayist.	*Date and Host.*	*To open Discussion.*
Dr. Reeves	March 22, Dr. Clark	Dr. Barnhart.
Dr. Shoup	April 26, Dr. Egbert	Dr. Battle.
To be selected	May—Annual Banquet.	
President's Address	October 25, Dr. Emmons	Dr. Braden.
Dr. Taylor	November 22, Dr. Frankland	Dr. Burbank.
Dr. Van Sweringen	December 20, Dr. Gibson	Dr. Clark.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY.—President, J. F. Moran; Vice Presidents, G. B. Miller, Prentiss Willson; Secretary, Truman Abbe; Treasurer, D. W. Prentiss. Retired Members—Drs. G. N. Acker, S. S. Adams, E. A. Balloch, J. W. Bovée, W. S. Bowen, W. P. Carr, G. Wythe Cook, M. F. Cuthbert, Henry D. Fry, H. L. E. Johnson, J. T. Johnson, D. G. Lewis, A. R. Shands, E. E. Morse, Elmer Sothoron, J. Ford Thompson, John Van Rensselaer.

Program—1915.

Date.	*Essayist.*	*Reporters.*	*Host.*
March 12	Dr. T. S. Grasty	Dr. J. L. Riggles Dr. W. M. Sprigg.	Dr. W. R. Moulden.
April 9	Dr. Joseph Wall	Dr. T. S. Lowe Dr. T. E. Neill.	Dr. Stone.
May 14	Dr. G. B. Miller	Dr. H. W. Lawson Dr. Howard Hume.	Dr. Sprigg.
October 8	Dr. J. F. Moran	President's Address Election of Officers.	Dr. Lowe.
November 12	Dr. S. L. Owens	Dr. Karl Corley Dr. R. Y. Sullivan.	Dr. Prentiss.
December 10	Dr. John Foote	Dr. L. A. Martel Dr. C. S. White.	Dr. Riggles.

WASHINGTON SOCIETY OF NERVOUS AND MENTAL DISEASES.—President, Wm. H. Hough; Vice President, Bernard Glueck; Secretary, J. J. Madigan. The Society has a limited membership of thirty, but welcomes Physicans and Surgeons interested in Neurology and Psychiatry. Meets monthly on the third Thursday at the Cosmos Club or a member's residence.

WOMEN'S MEDICAL SOCIETY of the District of Columbia. President, Sophie Nordhoff-Jung; Vice President, Ada R. Thomas; Secretary and Treasurer, A. Francis Foye; Corresponding Secretary, Margaret R. Stewart.

THE SECRETARIES of the other Medical Societies of this District are reminded that the ANNALS will publish the schedules of their meetings.

THE WASHINGTON MEDICAL ANNALS.—Back numbers.—Members of the Society who have back numbers of the ANNALS, and do not intend to preserve them, are requested to send them to the Chairman of the Publication Committee. Requests for such numbers are frequently received. Address Dr. D. S. Lamb, Army Medical Museum.

THE TRAVEL STUDY TOUR of the Travel Study Club of American Physicians to the A. M. A. meeting, San Francisco Exposition, Honolulu, Japan, the Philippines, China, and around the world, 1915. Those interested address the business manager of the McCann's Tours, 1328 Broadway and 34th Street, N. Y. City.

DR. D. S. LAMB has a number of photographs left over from the publication of the History of the Medical Society that have not been called for. These or any of them can be obtained by any member of the Society who will call at the Army Medical Museum.

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS.—The following amendments have been made since the publication in Volume XII, March 1913.

Constitution.—Article V, Section 4; adopted Nov. 4, 1914: before the words "Due notice" on page 142, insert "No application for membership that is rejected or withdrawn shall be renewed until after two years from the time of its rejection or withdrawal."

Section 10, same article; adopted Jan. 7, 1914: for "two years" substitute "one year."

Arcticle VI, Section 5, adopted Jan. 6, 1915: in the last line, for "two" substitute "three."

Article VIII, Section 2, page 148, 4th line from top: for the word "disorders" substitute the word "diseases."

By-Laws.—Article VIII, Section 9, page 153: adopted Jan. 7, 1914: No member of the Staff of any hospital receiving patients in private rooms shall attend such private patient sent to the hospital by a member of the Society, not a member of the Staff, unless specifically requested to do so by the attending physician.

Please note that the figures in Sections 7 and 8 of this article, instead of being 7 and 8 should be 5 and 6.

Belgian Physicians Relief.—Dr. F. F. Simpson, 7048 Jemkins Arcade, Pittsburgh, Pa., Treasurer of the Committee of American Physicians for the aid of the Belgian Profession, will receive contributions. The following is an extract from a letter from Dr. J. Riddle Goffe under date of January 26, 1915:

"The fact that the English Government has announced that it will no longer continue to grant its monthly stipend to the British Commission for Relief in Belgium comes with somewhat startling disappointment. The work of relief must now depend almost exclusively upon contributions from the United States. This means that our efforts must be redoubled if we are eventually to reap the benefit of what has already been done and carry the Belgian people through to the time when their own meager harvest can supply their actual necessities. It must be constantly kept in mind that 1,400,000 utterly destitute in Belgium are still standing in the bread line or hovering around the soup kitchens. A recent communication from Dr. Jacobs, of Brussels, gives a heartrending picture of the condition of Belgian civilian physicians and their families."

Dr. T. A. Williams, 1705 N St., N. W., a committee on collecting instruments for Belgian Physicians, will be glad to receive any instruments that members of the Society can spare, however old such instruments may be. Kindly send to Dr. Williams or notify him that you can contribute them.

The Interstate Association of Anesthetists will hold its organization meeting in conjunction with the Ohio State Medical Association in Cincinnati, Ohio, May 4–5, 1915, at which time an elaborate scientific program, devoted exclusively to advances in anesthesia and analgesia will be presented.

Headquarters, assembly room and exhibits will be in the New Hotel Gibson, in which all the Sections of the Ohio State Medical Association will also meet. An informal organization dinner will be served on the evening of May 4, after which the visiting anesthetists will be the guests at a smoker of the local entertainment committee, headed by Dr. E. O. Smith. Visiting ladies will be entertained by Dr. Nora Crotty and her committee at a reception and theater party.

Anesthetists, surgical and dental, as well as interested surgeons and general practitioners, who wish to participate in the proceedings are cordially invited to attend. For further information and dinner reservations address F. H. McMechan, M. D., Secretary, 1044 Wesley Ave., Cincinnati, Ohio.

The Harrison Narcotic Law; its history. It appears that the first bill was drawn by a member of this Society, Dr. Hamilton K. Wright, who was a delegate to the Hague Opium Conference. About six years ago he induced Congressman Foster, of Vermont, to introduce a bill into the House of Representatives. It is stated that all the national societies of pharmacy approved the bill, but that as drawn it was not practicable. In the meantime Foster died. Then Dr. Wright interested Congressman Harrison, after whom the final bill is named. Harrison was afterwards made the Governor of the Philippines. He pushed the matter, but his bill was also impracticable. A conference of pharmacy associations was held, now known as the National Drug Trade Conference, composed of the various pharmaceutical societies. There was a hearing before the committee of Congress, the result of which was that Dr. Wright and the conference were told to formulate a satisfactory bill. The American Medical Association was represented. A bill was drafted that finally passed.

The Cancer Problem.—The Medical Society of the State of Pennsylvania, through its subcommittee on cancer, has appealed to every medical journal in the United States to devote its July number to a symposium on cancer, in order to arouse more interest among physicians, especially with regard to the early *warning* symptoms of the disease, and the need of prompt treatment. We are asked to publish the following:

"Physicians, will you help reduce cancer mortality? Every year 75,000 persons in the United States die from cancer. The public is gradually becoming alive to the cancer *menace* and will soon demand more active efforts from us. Are you doing all you can to diminish cancer mortality among your patients? You can help by always being on the watch to make an early diagnosis, and by insisting on proper treatment without delay."

The Medical Society of the State of New York will hold its 109th annual meeting in Buffalo April 27–29. A general invitation is given all physicians to attend irrespective of residence.

For information address Dr. E. A. Sharp, 481 Franklin Street, Buffalo.

THIS IS THE WAY the *Old Dominion Journal* got it: "For 1915 the Medical Society of the District of Columbia elected Dr. Frank Leech, President; Dr. A. L. Stavelay and A. P. Boswell, Vice Presidents; Drs. A. L. Hunt and H. C. Macatee, Secretaries, and Dr. C. W. Franzion, Treasurer."

THE "HOSPITAL NEWS" for March is got up in the usual handsome style, with articles by Drs. Fry, Moran, Webb and Surgeon General Rupert Blue, besides miscellaneous matter. There are good pictures of Drs. Barton, Wells, Newton and Blue, besides other illustrations. Mr. Sturgeon is the manager, Drs. Barton and Wells are the editors, and the new office is at the Blackistone, corner 14th and H Sts., N. W. The subscription is $1.50 a year.

DR. L. M. BABENDREIER, of this Society, is reported to have died March 7 at Alpena, W. Va., of tuberculosis; buried in Baltimore.

DR. JOSEPH H. MOORE, Missouri Medical College, 1873, sometime chief of staff of Quarantine Hospital, St. Louis, during a yellow fever epidemic, for many years a specialist in electrotherapeutics in Washington, died February 14, age 65.

RECENT PUBLICATIONS BY PHYSICIANS IN THE DISTRICT OF COLUMBIA.

F. B. Bishop; The direct current as a factor in the treatment of disease. Reprint.

E. M. Blackwell, U. S. N.; The proposed personnel organization and equipment of hospital ship; *U. S. Naval Med. Bull.*, January, page 28.

Rupert Blue, P. H. S.; Antiplague measures with special reference to the New Orleans campaign; *South. Med. Jour.*, February, page 85.

W. P. Carr; The prognosis and conservative treatment of fractures; notably end results; *Va. Med. Semi-Mo.*, January 22, page 495; abstracted in *Amer. Jour. Surgery*, March, page 128.

A. C. Christie, U. S. A.; Manual of x-ray technic. Published by Lippincott, Philadelphia; 42 illustrations; price $2.00.

Taliafero Clark, P. H. S.; Public Health administration in West Virginia; Reprint 252, from Public Health Reports, January 22.

W. M. Clark; Reaction of cow's milk modified for infant feed-

ing; *Jour. Med. Research,* January; abstracted in *Jour. A. M. A.,* February 20.

G. Wythe Cook; History of medical ethics; *N. Y. Med. Jour.,* January 23 and 30.

R. H. Creel; Examination of drinking water on railroad trains; Bull. 100, Hygienic Laboratory, November.

A. C. Evans; Bacillus abortus in market milk; *Jour. Wash. Acad. Sci.,* Feb. 19, page 122.

L. D. Fricks, P. H. S.; Rocky Mountain spotted fever; Reprint 251 from Public Health Reports, January 15.

H. D. Fry; The critical periods of a woman's life; *Hospital News,* March, page 11.

F. H. Garrison; The medical periodical and the scientific society; *N. O. Med. and Surg. Jour.,* December. Also, Ductless glands, internal secretions, and hormone equilibrium; *Pop. Sci. Monthly,* December, January and February.

C. T. Grayson; Old-time physicians; *Southern Med. Jour.,* January.

F. R. Hagner; The Bulgaria bacillus in cystitis with alkaline urine; *Jour. A. M. A.,* January 30, page 465.

Milton Hahn; Erythema nodosum with facial paralysis and hemiplegia; *Amer. Jour. Obstet.,* January.

W. H. Huntington; Report of case of latent mastoiditis with sinus thrombosis; *Va. Med. Semi-Mo.,* February 12, page 533.

Frederick Knab and August Busck; Mosquitoes and sewerage disposal; *Amer. Jour. Trp. Dis.,* November; abstacted in *South. Med. Jour.,* March, page 208.

L. Kolipinski; Auscultoplectrum, combined stethoscope and percussion hammer; *N. Y. Med. Jour.,* January 30.

J. E. Lind; The treatment of bedsores; *N. Y. Med. Jour.,* January 2. Also, The early diagnosis of general paresis; *International Clinics,* March.

R. M. Little; Experiences with marine expeditionary force in Mexico; *U. S. Naval Med. Bull.,* January, page 76.

F. E. McCullough, U. S. N.; Best training for hospital corps in fleet; *Military Surgeon,* January.

Arthur McDonald; Principles of criminal anthropology; *Public Health Jour.,* Toronto, December.

M. G. Motter and M. I. Wilbert; Digest of comments on the Pharmacopoeia of the United States of America (8th decennial revision) and on the National Formulary (third edition), for the year 1913; Hygienic Laboratory, Bull. 981, November, 1914.

M. G. Motter; Hookworm disease; the use of oil of chenopodium in its treatment; Reprint 224 U. S. P. H. S., 1914; abstracted in *Eclectic Med. Jour.,* February, page 94.

H. J. Nichols, U. S. A.; Observations on experimental typhoid infection of the gallbladder in the rabbit; *Jour. Exper. Med.*

E. C. Prentiss; Infection with the cercomona hominis; *N. Y. Med. Jour.,* December.

B. M. Randolph; Sciatica, a symptom of appendicitis; *Jour. A. M. A.*, Feb. 13, page 579.

C. W. Richardson; Some observations on intranasal surgery; *New Albany Med. Herald*, January; abstracted in *Jour. Kansas Med. Soc.*, February, page 59.

J. J. Richardson; Vincent's angina; *Annals Otol., Rhinol., and Laryngol.*, June, 1914; abstracted in *Eclectic Med. Jour.*, February, page 88.

G. B. Roth; Pituitary standardization, a comparison of the physiological activity of some commercial pituitary preparations; Bull. 100, Hygienic Laboratory, November.

W. Salant and S. Hecht; Influence of oxalates, citrates and tartrates on isolated heart; *Amer. Jour. Physiology*, January; abstracted in *Jour. A. M. A.*, February 20, page 694.

F. M. Scales; Enzymes of aspergillus torsicola; *Jour. Biol. Chem.*, December.

J. W. Schereschewsky, P. H. S.; Physical examination of workers; Reprint 234 from Pub. Hlth. Reports, November 20, 1914.

Atherton Seidell and Frederic Fenger; Variation in the epinephrin content of suprarenal glands; Bull. 100, Hygienic Laboratory, November.

A. R. Shands; The operative treatment of fractures; *Va. Med. Semi-Mo.*, January 22, page 501.

R. W. Shufeldt, U. S. A.; Comparative study of certain cranial sutures in the primates; *Anat. Record*, January 20, page 121.

C. A. Simpson; The relative value of radium and x-ray treatment of skin diseases and cancer; *South. Med. Jour.*, October. Reprint.

D. G. Smith; Unusual case of anaphylaxis following administration of tetanus antitoxin; WASH. MED. ANNALS, January, page 18; abstracted in *Jour. A. M. A.*, Feb. 6, page 544, and *South. Med. Jour.*, March, page 241.

G. T. Smith, U. S. N.; The treatment of chronic posterior nephritis; *U. S. Naval Med. Bull.*, January, page 80.

R. Spear, U. S. N.; Case of reamputation of leg; Same jour., January, page 122.

I. S. Stone; Temperature range after supravaginal hysterectomy for myofibromata; *Surg. Gynec. and Obstet.*, February.

J. K. Thibault, Jr.; Comparative study of the losses of rural industries from malarial mosquitoes; *South. Med. Jour.*, March, page 195.

D. L. Van Dine; The losses to rural industries through mosquitoes that convey malaria; Same jour., page 184.

G. T. Vaughan; Experience of a surgeon during the occupation of Vera Cruz; *U. S. Naval Med. Bull.*, January, page 75.

B. S. Warren, P. H. S.; Sickness insurance; Reprint 250 from Pub. Hlth. Reports, January 8.

E. R. Whitmore; Antityphoid vaccination; *Penna. Med. Jour.*, January, page 258.

A. W. Williams, U. S. A.; Appendicitis under field service conditions; *N. Y. Med. Jour.*, January 2.

T. A. Williams; Cause and cure of night terrors in children; *Arch. Pediat.*, December. Also, Neurotic disturbances after accidents in relation to workmen's compensation; *N. Y. Med. Jour.*, January 1. Also, Spurious and genuine treatment of psychoneurosis, illustrated by cases; *Illinois Med. Jour.*, October; abstracted in *Louisville, Mo., Jour. Med. and Surg.*, March, page 317. Also, Remarks on intrathecal injection as a factor in the improvement of tabetics after salvarsan; *Alienist and Neurologist*, November; abstracted in *West Va. Med. Jour.*, February, page 277. Also, Prevention of suicide; *Amer. Jour. Insanity*, January.

W. C. Woodward; Efficiency and economy in maintenance of private agencies working for public health; *Amer. Jour. Pub. Hlth.*, January.

PERSONAL NOTES.

Dr. C. W. Chancellor died in this city January 3; age, 84.

Dr. N. A. Cook, of the Department of Agriculture, was elected Vice-President of the American Microscopical Society at the recent meeting in Philadelphia.

Dr. P. L. Freeman, U. S. A., has been ordered to duty at the Walter Reed Hospital.

Surgeon General Gorgas has been made a Major-General.

Dr. R. M. Kennedy, U. S. Navy, has been detached from the Naval Dispensary to the *Solace*.

Dr. G. M. Kober attended the meeting of the Conference on Medical Education, Chicago, February 16.

Dr. C. H. T. Lowndes, U. S. Navy, ordered to the Naval Dispensary.

Dr. G. F. Lull, U. S. A., ordered to the Canal Zone.

Dr. Philip Newton of this Society, serving with the Red Cross, was married, January 22, at Petrograd, to Princess Helene Schafrofskaya.

Dr. E. E. Person, U. S. A., from Army War College to Canal Zone.

Dr. C. C. Pierce, P. H. S., ordered to San Francisco, to superintend instalment, and take charge of exhibit of the service, at the Panama-Pacific Exposition.

Dr. L. Sheldon, U. S. Navy, ordered to Naval Dispensary.

Dr. H. D. Snyder, U. S. A., ordered to Canal Zone.

Dr. J. Stepp, U. S. Navy, ordered to Marine Barracks.

Dr. J. W. Van Dusen, U. S. A., ordered to duty in Surgeon-General's Office.

Dr. A. M. Whaley, U. S. A., ordered to duty as Attending Surgeon this city.

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WASHINGTON
MEDICAL ANNALS

CASE OF CESAREAN SECTION IN BREECH PRESENTATION.*

By W. Sinclair Bowen, M. D.,

Washington, D. C.

Some months ago I was engaged to attend Mrs. A., white, age 40, in her first confinement. She was a large woman, weighing 160 pounds, with normal pelvic measurements. Her pregnancy was fairly normal except for the first three months when there were marked digestive disturbances, and some maniacal symptoms.

She and her husband both felt that it was probably their last and only chance for offspring, and both impressed upon me their great desire for a living child.

Upon making the usual examination, by abdominal palpation, at the end of the eighth month, I was disappointed to find a breech presentation. At this time I endeavored, by gentle manipulation, to change the breech to a vertex presentation by external version, but did not succeed. This same attempt was repeated each succeeding week, until the end of term, with the same unsuccessful result.

I explained the situation fully to the husband and his wife, and advised that she go to the hospital as soon labor began. This was consented to and followed out.

I remained with the patient most of the time during a trial labor of twenty hours. She then began to show signs of exhaustion, and it was evident that delivery should be effected without further delay. The breech was somewhat moulded in the upper part of the pelvic cavity, the os was dilated only about the size of a quarter dollar, and the vagina and perineum not easily dilatable. The question to be decided lay between three procedures:

1st. A further trial at spontaneous delivery.

2d. Delivery by *accouchement forcé per vias naturales.*

3d. Abdominal Cesarean Section.

The *pros* and *cons* of these three methods of delivery were explained to the husband and wife, after which I was asked to state

* Read before the Medical Society March 17, 1915.

my preference. I decided upon abdominal Cesarean Section as the safest and best for all concerned under the circumstances. Accordingly this plan was carried out at once, and a female child was delivered, weighing seven pounds and four ounces.

The mother and baby left the hospital at the end of three weeks in splendid condition. Convalescence was quite as easy as any normal delivery could be.

When it was put up to me to decide upon the method of delivery in this case, I confess to some misgiving in selecting the method, as I did not at that time know that abdominal Cesarean Section had been done before under similar circumstances. Nor would we think it had by close study of some of the most modern and best text books on obstetrics.

For my guidance in the future I would greatly appreciate a discussion on the following points:

1st. Is Cesarean Section ever justifiable in breech presentation in a primipara?

2d. If it is, under what circumstances should it be done?

3d. Should we give the the patient a trial labor, or should an elective Cesarean Section be performed?

If we do not give them a trial labor, how do we know but that labor may end spontaneously and safely to mother and child? Some cases of breech presentation are delivered easily and spontaneously, and others with the greatest difficulty, ending possibly in still-birth.

I would ask those who advise an elective Cesarean Section in these cases, would they perform it in all primipara with breech or only in those of a certain age? If so, what age limit do they advise?

I feel that a discussion along the line suggested above would tend to lessen the infant death rate, which is large in this particular class of cases.

[Dr. Bowen wrote letters to many prominent obstetrical men asking their opinion and criticism of his treatment in this case.

The following are extracts from the answers received:

Dr. J. Whitridge Williams, Baltimore, Md.: "I think you are to be congratulated upon the outcome of the case. My only critiscism would be that you waited twenty hours instead of operating at the onset of labor. The mortality in late operation is about 10 per cent. as compared with 1 or 2 per cent. in early operation."

Dr. J. B. DeLee, Chicago, Ill.: "Twenty years ago, in discussing a paper advocating Cesarean Section in these cases, I disagreed with its author, believing that a live child could be delivered through the natural channel. I still think this possible in many cases, although I have wished that an abdominal section had been done on many occasions. Owing to the advance made

in operative technique in the past twenty years, I believe abdominal Cesarean Section justifiable under the circumstances mentioned."

Dr. J. F. Moran, Washington, D. C.: "Under the conditions mentioned with patient showing signs of fatigue, evidenced by increased pulse rate, uterine inertia, etc., Cesarean Section was not only justifiable but a rational method of procedure, even though the pelvic measurements be normal. If bag of waters were intact and condition of mother and child favorable, some would advocate further trial aided with sedatives. Instead of putting forth 'the desire for a live child' I would make it stronger by substituting 'the inherent moral and legal right of the child to be born alive.' I had two somewhat similar cases in one of which I resorted to slow extraction, lost the baby and got severe perineal lacerations. In the other case, abdominal Cesarean Section was done with happy results to mother and child."

Dr. Henry D. Fry, Washington, D. C.: "I am prepared to accept the position that, given an elderly primipara, breech presentation, large child, do an elective abdominal Cesarean Section. I do not think it establishes a precedent which should be followed under all such circumstances. The maternal mortality is greater in an abdominal section after twenty hours of labor than if delivery had been done *per vaginam*. If parents were willing to take the risk, you were justified in performing the operation. The alternative line of treatment would have been manual dilatation of the cervix or vaginal Cesarean Section."

Dr. Edward P. Davis, Philadelphia, Pa.: "I think abdominal section was the only treatment clearly indicated in the case described by you."

Dr. George W. Dobbin, Baltimore, Md.: "I think you were perfectly right in doing as you did. I believe that abdominal section done at the beginning of labor instead of after twenty hours of ineffectual pains would have given the mother less chance of complications. I am interested in the subject of broadening the indications for Cesarean Section under suitable and proper conditions."

Dr. Edwin B. Cragian, New York: "I can easily conceive of a primagravida of forty in which Cesarean Section would be the best method of delivery. The burden of proof is on the other side, as the proof of the pudding is the eating. I congratulate the parents and the operator."

Dr. Barton Cooke Hirst, Philadelphia, Pa.: "Your treatment of patient as described, in my opinion was entirely correct. I would have carried out the same plan myself. In view of the successful result I should think you would feel quite satisfied that you had done the right thing."

Dr. G. Brown Miller, Washington, D. C.: "As everything turned out your treatment was eminently successful. Under the

circumstances you did the correct thing. According to text books you should have waited and most probably the child would have been born naturally. I believe the patients' wishes should be consulted, and this in an old primipara with breech presentation, renders the operation justifiable. However, with the hysteria pervading the medical profession (those who do obstetrics) for Cesarean Section without due regard for proper indications, we should be very careful to advocate the operation only when absolutely indicated. I believe that in the case you cite, if there was no great danger of infection and a fair trial labor given, Cesarean Section is indicated."

Dr. William Mercer Sprigg, Washington, D. C.: "I would not advise Cesarean Section as a means of delivery in breech cases as a wise practice. I can but agree with you in this individual case with trial labor without progress for twenty hours. The chance for a living child was undoubtedly better by Cesarean operation."

Dr. Prentiss Willson, Washington, D. C.: "I feel that a case of this character will in the near future be considered a strong indication for Cesarean Section without much temporizing with trial labors."

Dr. William A. Jack, Jr., Washington, D. C.: "I would say that your treatment was correct. To my mind abdominal hysterotomy is the ideal method of delivery in aged primiparas."

Dr. A. L. Stavely, Washington, D. C.: "I believe the plan you suggest for delivery is perfectly proper. An elective section is almost devoid of risk to mother and child. Delivery 'per vias naturales' is accompanied by so many harmful possibilities that I would not hesitate to offer Cesarean Section."]

Dr. Fry said that he had already discussed this case at another time, but would repeat what he had said. He had been asked his opinion as to the justification of doing a Cesarean Section in such a case; he had replied that the outcome of the case would disarm any criticism of the management; his objection to the management was the delay in doing the section. The mortality of Cesarean Section is greater after delay, and the combination of circumstances in this case would, in his opinion, have made an elective Cesarean Section decidedly indicated. A trial labor in an elderly primipara with a breech presentation should not be allowed to proceed long. He had recently been confronted by such a case, the patient having been thirty-six hours in labor; in this instance he did not consider section justifiable. Labor was terminated by a very difficult delivery of a dead child. If we are to do good obstetric work in Washington we must make up our minds as to what are the explicit indications for Cesarean Section in all possible conditions. He had looked up the subject in all the prominent modern text books of obstetrics, and not one had mentioned Cesarean Section as the proper treatment of breech presentations in elderly primiparae.

Dr. I. S. Stone did not rise to speak as an obstetrician; he had rather hoped to hear a full discussion of the subject by the obstetricians. He had heard this case discussed before, and he had said at first that in his opinion Cesarean Section was not indicated. But since endorsement of this mode of treatment in such cases had come from so many directions, he had been inclined to think that this is one more of the advances in modern obstetric procedure. He wished to remark, however, that he had never yet addressed an inquiry as to the propriety of some surgical procedure to his colleagues but that they with great unanimity approved his course. He held to the opinion that we are departing from the conservative methods so long laid down in the books and so long practiced with success. It is not easy to write down strict rules for action in obstetric cases; symptoms which will cause one man to be alarmed will not excite alarm in another. In Dr. Bowen's case the patient had shown signs of exhaustion after twenty hours of labor; there still remained a question in Dr. Stone's mind whether the administration of sedatives, in the old conservative way, might not have been followed by dilatation and natural delivery. Everywhere, however, the tendency in obstetrics is to resort to methods of quick and radical delivery.

Dr. A. B. Hooe had been much interested in the case and in the discussion. The questions proposed in Dr. Bowen's paper, it seemed to him, had been properly answered by the methods adopted in the management of the case. There can be no doubt that Cesarean Section is a much less formidable operation than a difficult forceps extraction. No hard and fast rule, however, could be laid down for the management of cases such as Dr. Bowen had reported; the proper course will always depend upon the circumstances arising in each case.

Dr. A. L. Stavely agreed quite closely with what Dr. Fry had said. Dr. Bowen had asked Dr. Stavely's opinion about the case and he had given it in about the same terms as had Dr. Fry. With a full comprehension of the situation by both parents and a great desire for a living child, it seems quite appropriate to do Cesarean Section in similar cases. When we realize that the foetal mortality from after-coming head is 10 per cent., whereas it is but 2 per cent. after Cesarean Section, the question as to the propriety of the section should be easily answered.

Dr. Chappell believed that Cesarean Section in experienced hands is decidedly preferable to a severely lacerated perineum or to a dead child; if the obstetrician deems either of the accidents just mentioned imminent, then section should be done. According to the old rules, we were to perform Cesarean Section only when the pelvic measurements fell below extremely small figures; with any experience at all, any physician should recognize these extreme cases. It is the borderland cases that are difficult to decide upon; but the difficulty need not be great, if there is a well-

justified fear of a severely lacerated perineum or a dead child. He had had only one case sectioned; there had been no mistake in that one. He expressed the belief that he may have made mistakes in not resorting to section in other cases. We have been taught that section ought not to be done after long continued labors; he did not believe that this should constitute a contraindication if it were pretty clear that modern antiseptic methods had been employed in the preliminary efforts at delivery.

Dr. Frankland said that the paper and the discussion had been very interesting. All the speakers had expressed clear and interesting views as well as reasons for their views. Dr. Stone had spoken of the personal equation as affecting the decision in such cases; to Dr. Frankland's mind there were three personal equations to consider; the obstetrician's personal bias would enter largely into a determination of the course to pursue, but more important would be the temperament of the mother and the size and vigor of the child. As to Dr. Chappell's remarks about modern antiseptic methods, nowadays there are not many vaginal examinations made, and on this account a prolonged labor might not jeopardize the success of Cesarean Section.

Dr. Martel was sorry that Dr. Bowen could not be present to close the discussion. [Dr. Martel read extracts from letters giving the opinions of prominent obstetricians of this and other cities upon Dr. Bowen's course in this case. See above.]

Dr. Fry was now engaged in efforts to devise an accurate method of estimating the size of the foetus *in utero;* when this can be done, it will afford an additional criterion for doing an elective Cesarean Section. As Dr. Chappell had suggested, the expected morbidity is a factor to be seriously considered; the morbidity of the perineum is much greater than the morbidity from section. Especially has the modern, high two-and-a-half inch incision decreased the morbidity following Cesarean Section.

WANTED IN WYOMING.—Said a member of a delegation from the Lone Star State in a burst of oratory:

"We represent the great State of Texas. The first white woman born in Texas is still living—she now has a population of over three millions."

There was a pause of bewilderment for a moment, and then a voice from the gallery rang out clear and distinct: "Send that woman out to Wyoming—we need her."—*Chicago Med. Record.*

EPILEPSY IN YOUNG ADULTS AND ADOLESCENTS, WITH REFERENCE TO A NEW TREATMENT BASED UPON PATHOGENESIS.*

By Tom A. Williams, M. D., C. M. (Edinburgh),

Washington, D. C.

It is supposed that a special irritability of the cerebral cortex is a prerequiste to the manifestation of epileptic convulsions. In favor of this hypothesis are invoked many facts. In the first place, it is frequent to find in the ascendants or collaterals of epileptics either epilepsy itself or some other dyscrasia, often showing itself through the nervous system, whether in the life of relation by irritable or violent temper, eccentricity, feeble mindedness, or what is loosely called neurasthenia and hysteria, or in the vegetative life itself, as by a feeble body, of poor resistance to tuberculosis and acute infection, an addiction to drugs like alcohol, or an incapacity or unwillingness to work steadily or hard.

When analyzed, these facts do not prove that the cerebrum itself is degenerate, for this interpretation does not take into account the bodily determinants of cerebration, such as the respiration, circulation, the metabolism of food, and the internal secretions, the disorder of any of which seriously impairs cerebral function.

I shall not enlarge upon this fruitful theme, for experienced clinicians will appreciate its importance at once, while for others a treatise would have to be written.

A second fact often used to support the hypothesis that epilepsy is a disorder of the cerebrum is its onset after injury or disease of the brain, such as is produced by tumor, sclerosed neuroglia or vessels.

Even here we cannot in justice dogmatize, for we know that not every arterio-sclerosis, cortical tumor, or blow on the head gives rise to convulsions by any means. So that we cannot without specific investigation exclude the likelihood of parabolic products being the real producer of the convulsions which occur. That such is the case even in these patients we have no proof, it is true, but presumptive clinical evidence offers itself. The case which follows is a common enough type to give good illustration:

Epilepsy from Vascular Cerebral Lesion Removed by Metabolic Means.—A man of 64, chief architect in the Indian Service, consulted me February 10, 1910, having been sent by Dr. Philip S. Roy, because of the recent occurrence of epileptiform convulsions with loss of consciousness.

The first attack had occurred in May, 1909, at an elevation of

* Read before the Medical Society November 25, 1914.

12,000 feet, near Durango, while he was inspecting the school buildings there. He was unconscious for half an hour. The second attack occurred shortly after, upon leaving the train in Chicago, while making for the staircase. It lasted about an hour. A third attack took place in his office that July, lasting one and a half hours. The fourth, and last, had occurred two nights before his visit to me, while he was visiting a friend and sitting down. It lasted three hours.

The attacks are preceded by a creeping sensation in the left upper arm, passing slowly down to the hand, which becomes numb. In about fifteen minutes unconsciousness supervenes. The face is said to be flushed, but he is uncertain whether there are convulsions, though others have told him that there are. The durations of the attacks were only surmised.

Previous History.—Scarlet fever at 6, without bad sequelae. An active living, healthy man, except for two years of asthma 25 years before, a result of constant attacks of catarrh. It was cured by working as a farm hand for three weeks. He smokes two cigars and a pipe a day. He took coffee, and was a heavy drinker until after the attack, now he has ceased to take even tea. He has always been abstemious in eating, but has been fond of salty foods. He drank "when he felt like it." Since these attacks he has had a pain over the forehead when coryza occurred. As he had read that insanity might come on from this catarrh, he was at first a little anxious about his state, but soon steeled himself against it. The pain in the head was rather a feeling of depression and a grumbling pain, like that of catarrh. The discharge was slight, and the headache disappeared when it ceased. He used to sleep quite well, but about the time of his attacks began waking in the early morning, and could not fall asleep again. This persisted. He had been recommended to eat more and to take fat meat, and this he has done.

Physical Examination.—Reflexes. Knee kick, R. > L. Achilles reflex, R. > L. Triceps, L. > R. Radials equal. None markedly exaggerated. Plantar reflex is flexor. The left cremaster is absent. Sensibility: No abnormality in lower limbs to pain, touch, temperature or attitudes, though the latter are sometimes wrongly named, but correctly recognized. Arms, perfect localization of light touches, both segmentally and axilly. Spacing sense of fingers normal. Other modalities normal, except sense of attitudes poor, especially in the left hand. No hemiopia or color inversion of visual fields. Motility: Normal, but left fingers weaker than right. Diadocokinesis regular. Pupils contract promptly. Psychic functions: He thinks his memory is weakened since the attacks. There are no disorders of speech. Emotionally, he has always been easily excited when there was a cause, and has been accustomed to occasional sadness.

Diagnosis.—The localization of the aura in the left arm and

hand, along with the increase of the triceps reflex and the loss of the cremasteric, point to an organic perturbation of the sensori-motor area of the right hemisphere, probably mainly in or near the cortex of the central fissure, opposite the frontal convolution. The cremaster governing fibers are, of course, attacked in some other situations,

As neoplasm and granuloma were each unlikely, and as the man's age is that of arteriosclerosis, of the state preceding which the recently acquired matutinal insomnia was indicative, I believed it wise, although lacking proof, to adopt the supposition of sclerogenetic toxicosis, and put it to the experimental proof of therapeutics. Accordingly, a diet light in proteins was ordered, and coffee and tobacco were forbidden. The result was confirmatory, as the patient, one year from the consultation, remained free from attacks and insomnia, and perfectly well able to perform his very strenuous work, often in high altitudes.

I believe that the first attack was inaugurated in consequence of an ischemia of a part of the right Rolandic region, due to the heart, strained by the high altitude, not being able to keep full of blood a partially sclerosed vessel distributed to that area. The second attack was likewise due to a sudden demand upon the heart upon leaving the train after a very hot journey.

Thus although a sclerosed area still remained, the fits ceased when the metabolism was rectified.

This is true not only of epileptic convulsions, but of many varieties of cerebral malfunction such as vertigo, depressions, etc., concerning which I have already written: ("Detection and Treatment of Neurological Phenomena Preceding Arteriosclerosis." *The American Practitioner*, New York, February, 1914; *Month. Cyclo.*, 1911, &c.)

The above objections to the cerebral seat of epilepsy become pregnant in conjunction with the fact that in a perfectly healthy cerebrum, even in animals, a toxin, absinthe, will invariably produce an epileptic convulsion.

To the exogenous character of the absinthe poison as an illustration objection may be brought.

But in puerperal eclampsia, we find a state where an endogenous toxin causes convulsive attacks quite like those found in epilepsy, and that these occur in spite of an undamaged cerebrum no one denies. So that we have in them examples of convulsion purely functional, that is to say, occurring apart from structural changes in the cerebrum. Although in view of the possibilities suggested by alcoholic wet brain and uraemia where the mechanical effect of oedema may play a part in the genesis of the convulsions we cannot demonstrably postulate toxicosis as the direct cause of eclampsia, yet, at least a remediable toxicity is the ultimate source of the convulsions as there is no proof of oedema as the proximate source.

The Theory as to Pathogenesis and therefore Treatment of Epileptic Convulsions.—That the substances at work in uraemic eclamptic fits are metabolized proteins there is much evidence in the presence of these in abnormally large amount in blood and urine of such patients. Should we not expect then that a similar failure of nitrogen metabolism may be the ultimate cause of idiopathic epilepsy?

If so shall we not improve the condition of these patients by by minimizing the metabolic work to be done by them?

Now the standard diet of Vogt allows over 100 grams protein, and most diet customs approximate to this too. But Chittenden has shown that 50 grams is sufficient to maintain both body weight and muscular and mental efficiency, at least over many months. Shall we not find that patients who have convulsions when eating by custom or the Vogt standard cease to have them when their metabolic protein load is diminished to the Chittenden standard?

My cases may help to answer this question. Complete metabolic study would have been desirable. But with private patients and no laboratory collaboration, I have not found it possible hitherto. So this contribution is purely clinical except in case 1, where some study of the renal efficiency supports the preceding argument strongly.

Of course, mere amount of intake is only one factor of health in metabolism. The integrity of the organs of digestion, of internal secretion and of excretion is important; and of course the supply of oxygen to the tissues must not be forgotten. Hence, exercise and general hygiene must not be neglected even when a model diet is being followed.

Let me leave without development these physiological considerations and pass to clinical paradigms.

Cases of Epilepsy in Young Adults.—These consist of adolescents in whom one or more convulsive attacks, truly epileptic, appeared to be brought on by metabolic disturbance, the treatment of which at once led to the disappearance of the attacks. In one instance cessation of metabolic cautions led to relapse which was quickly terminated by the reassumption of care.

Scarlatinal Nephritis Followed by Epilepsy, Cessation of Attacks Under Treatment.—Case 1. A girl aged 14, was referred in January, 1914, by Drs. Spencer and Garnett because of epileptic attacks occurring at the age of ten and eleven and a half, and again three times during the winter of 1913. She loses consciousness for less than a minute, bites her tongue, loses the urine, sleeps heavily for an hour afterwards and has headache and is dizzy for some time after. The day preceding the attack the breath is exceedingly foul, and for some days there is a pustular eruption on the face; during last summer this had been present on the feet. No psychic disturbances were noticed before the attack; but she had been of irritable disposition until seeing a

play, "The Dawn of Tomorrow," illustrating a girl's bravery under misfortune. This stimulated her to better behavior. She was a blue baby, and when five years old had scarlet fever (followed by a weak back). At eleven, albumen was found abundant in the urine on several occasions. It is now reported to be very slight in amount. She had been dieted as follows: Breakfast: Fruit, cereal, a pint of milk, one egg, brown bread. Lunch: Oysters, brown bread, milk, custard or gelatine. Dinner: Fish, potatoes, milk, custard or gelatine. She takes 1½ quarts of milk a day and cocoa now and then. She drinks very little additional fluid and takes no salt. She is never constipated and has not yet menstruated, although the breasts have developed.

Examination.—The tongue is clear, there is no visible anemia, no caries of teeth, nutrition is good, but the muscles are inelastic. The reflexes are normal. Heart is irregular, with exaggerated pulmonic second sound, and slight hypertrophy of ventricles. She becomes livid when cold. Urine contains no albumin or casts; there is a strong indican reaction. Estimation of the renal function by phenolsulphone-phthalein showed 33 per cent. the first hour and 5 per cent. the second hour; this is distinctly below normal. (Dr. Fowler by Geraghty's method.) Dr. Frankland by his own method reported that the excretion began in five minutes and ended in three and a half hours, which he thought normal. Blood contained over six million red cells and an excess of haemoglobin. The stools were scybalous.

Treatment.—The special diet which I recommend in accordance with the principles described in this article was prescribed, and continuance of school and play were urged.

Another attack occurred, and she became constipated, as the purgatives which she had occasionally taken were forbidden. Figs, however, easily remedied this.

March 8 she was again seen. Reflexes were feeble, but she was in good spirits. The phthalein tests (Fowler) showed 35 per cent. the first hour, none in the second hour.

She was seen again April 9, continuing well. On May 23 Dr. Frankland reported somewhat slow elimination, some of the phthalein showing at the fifth hour. However, there have been no other attacks in spite of the fact that a week before this the breath became very foul and the child heavy, which the mother thought strongly suspicious. The diet was immediately restricted, for three meals, to fruit with milk and one slice of graham bread alone and two grains of calomel were given. Seen in September, the patient was thinner, brisker, happier and better in every way, no more attacks having occurred. In March, 1915, this patient remains well, cheerful and active, playing basket ball at school without detriment.

This case I interpret as a metabolic disturbance due to lowered renal function, probably from scarlatinal nephritis. Although the

renal function does not improve, yet, the special standard diet reduces to a minimum the toxicity of which the kidney must dispose; and hence accumulation is prevented; so that the fits no longer occur, in spite of the greatly lowered renal efficiency.

Epilepsy from Over Eating.—A clergyman's son, aged 16, was referred to me by Dr. Claytor January 22, 1911. He had been a healthy boy until January 9, when, while singing after lunch, he fell unconscious in convulsions preceded by deviation of the jaw to the left. There was no escape of urine, but he thinks he bit his tongue. There had been no convulsions in childhood, but transient strabismus had developed at four, after chickenpox. While he was at boarding school, aged nine, nightmares had developed after the alarm caused by a negro gun-outrage. They were supposed to be due to sleeping on the back, and his father cured him by persuading him not to do so.

The family history was negative. After the first attack, a systolic bruit was heard at the cardiac apex, which was to the left of the nipple. The urine was clear and without albumin.

The Attack.—A dazed feeling preceded a drawing of the mouth downwards and deviation of the jaw and a sense of falling; then consciousness was lost, he thinks, for five minutes. He awoke tired and stupid, and was frightened for over a minute. This was the only fit. He was sent to me because of his alarm at a conversation at lunch about a palsied doctor's twisted tongue. This caused him to flush and have a sensation as of another attack, which caused him to leave the table, saying "that jaw reminded me of my fit. I wish I knew what was the matter with me." His whole attitude was one of great apprehension about his condition.

Examination showed diminution of deep reflexes and absence of the plantar reflexes with, however, a prompt response of the tensor fasciae latae. The other cutaneous reflexes were prompt.

Sensibility was normal, and motility was unimpaired, except by the inferiority of the right diadocokinesis in a right-handed person. The visual fields were not inverted nor contracted, but the veins of the optic papillae were perhaps rather wide.

He has grown ten inches in two years, and he gained ten pounds in one month during the holidays, having eaten enormously of the dainties of the season. He had taken no exercise, and although he had slept much, he had kept late hours and taken a good deal of beer and tobacco.

The *diagnosis* was a functional epilepsy from disordered metabolism due to over eating, smoking and drinking with want of exercise, in a rapidly growing boy.

Treatment and Progress.—He was prescribed moderation in eating and athletics, no tobacco or alcohol and a loose collar and shirt. He was also reassured against his alarm. The inefficacy of the last device was shown when he returned to school, for

when the boys said "he looked bad," it affected him so that he wept and felt wretched for a long time. Furthermore, he had "a prickly feeling in the head and felt thoroughly useless about 11 A. M." This he attributed to the poor ventilation in the schoolroom, and he felt very heavy upon waking in the mornings. He was reassured, and secured permission for fifteen minutes recess out of doors every morning, and he left the track team for the gymnasium, the training for which prevented him eating between meals or smoking.

The diminution of the reflexes had ceased by February 15, and the improvement of his hysterical attitude was shown by the fact that the paralysis of a master, although it made him fear an attack, caused no flushing. He has enjoyed good health since then. I am informed of another attack, but I have no assurances regarding treatment.

Epilepsy of Three Years Duration Cured by Careful Metabolic Regulation.—Man of 24, was referred by Dr. Thomas Martin, September, 1911, on account of convulsions, the first of which occurred at 3 P. M. in April, 1908, after he had been up all night. He had been unconscious for a few minutes and languid for a few days. He returned to college, and six weeks later had a slight convulsion lasting for a minute after lunch. Knowing the attacks to be epileptic, he became very wretched though otherwise in good health. While in the diplomatic service, he was under the care of a consultant in London, and later went to Carlsbad, taking bromides all the time. Thence, in 1909, he went to South America and ceased the bromides. In October, 1910, an attack occurred in his sleep after he had been to a race meeting for two days and had taken a good deal of alcohol; he felt dazed in the morning. This alarmed him and he resumed the careful regime he had formerly followed; but in February, 1911, he began to walk in his sleep, and one day jumped over the banister. He consulted Dr. Pierce Bailey in New York, but had another attack while asleep in the train in the afternoon. But on July 4, he had an attack in the night after jumping horses at the show; August 19 an attack at home after returning from the seashore; September 7, after a day on train and motor; and, September 23, on arriving in Washington.

The attacks are like nightmares, they are without premonition; but one day he was dizzy several times before an attack. He does not bite his tongue nor micturate; but before losing consciousness he tries to rise from his pillow. He foams at the mouth, turns his head to the right and makes a grunting noise; but only the first attack had been witnessed by others. After the attacks there is dulness followed by restlessness for a day or so. He may be irritable for days preceding and following the attacks. While in England he had dizziness, especially after eating, while

reading or writing, when he would lose or fail to recall the sense of a word.

A year after leaving his London physician he had taken wine at meals or "whatever was going;" but he had ceased wine since October, 1910. His appetite is hearty, and he eats fast. He is sometimes constipated. He was circumcised when ten days old. Nocturnal incontinence had occurred occasionally until nine, though he was trained before two. There were no convulsions in infancy. He was not a nervous child, and had always been of calm temperament and easy to manage. His birth was not difficult, but he has a very long head which is not a family characteristic.

There is a history of sudden drop of pulse rate to forty and of urine of high specific gravity, but all Dr. Martin found was hyperacid urine, with s.g. 1017, a trace of indican, and an excess of chlorhydric acid in the stomach.

My examination showed normal deep knee reflexes, but an absent plantar reflex except in the outer toes, which, however, extend at the distal points, when Chaddock's mode of stimulation is employed, while they flex at the metatarsal joint. Other cutaneous reflexes are also diminished, but the pupil reactions are prompt and well maintained, and the sensibility and motility were unimpaired.

He was prescribed the model diet, and advised to take moderate and regular exercise, and a good prognosis was given, because his attacks were so evidently the consequence of metabolic disturbances due on some occasions to overexhaustion and on others to the stagnation of the circulation due to the too sedentary position for many hours. He returned in December, 1911, and and had had no further attacks, in consequence of which there was much relief of the great anxiety which had made him miserable. The importance of perseverance in his treatment was urged upon him, as he was told that each relapse would be more difficult to control.

I hear that he has had no further attacks and is active and happy March, 1915.

The relations between epilepsy of aberrant types and migraine are numerous; even instances where the two conditions have alternated, have been reported. Gowers especially has collected many instances of transitional forms of the two conditions. The data of this paper seem to furnish a further resemblance between migraine and epilepsy so fundamental as a common pathogenetic factor for patients subjected to a low protein dietary of the kind indicated above either cease to have headaches or to have them so mildly and rarely as to regard themselves as virtually cured. A publication on this subject is in preparation. I select an example.

Case IV. Recurrent Headaches and Epilepsy. Metabolic Mi-

graine Resembling Petit Mal. — A bacteriologist, aged 30, was referred to me in the spring of 1912 by Dr. Paul Johnson, because of attacks he called "bilious" (but not preceded nor accompanied by constipation), which produce headache preceded by numbness and pricking in the fingers, followed by dizziness, mental confusion and foolish talk of paraphasic type, without loss of consciousness. These attacks have occurred every two or three months since the age of 22; they are of very short duration. There were no scotomata, but they were formerly accompanied by vomiting. The headache is of the splitting kind, lasts all day and is followed by dulness and slowness of thought the day following. The capacity to concentrate his thoughts is increasingly impaired even between the attacks. He is at times irritable.

He has no bad habits, and apart from these attacks he is well and strong.

He received a blow on the left side of the head as a boy, and there is still a dent in the left parietal region, upon which side the headache more often occurs. He has a large appetite, which he says he controls, but he eats meat thrice a day, although he says sparingly. The blood pressure is not raised, the reflexes and sensibility are normal.

Treatment and Progress.—He was given the low protein "standard" diet. He wrote me the following winter: "Since I have reduced the amount of protein in my diet and increased the quantity of vegetables I have had no recurrence of those spells." Dr. Johnson informs me that he remains well to date.

Explanation of Effects of Emotion.—The theory advanced is not inconsistent with the tendency, well known to psychiatrists, of emotion to precipitate convulsive attacks of truly epileptic nature in disposed individuals quite apart from hysteria.

The explanation is the interference of emotional reaction of an intense kind with nutrition. Physiological experiment has shown how rapidly the flow of salivary, gastric and intestinal juice is suppressed in dogs by fear. Clinical observation is familiar with the production by emotion of the dry mouth, the stagnant stomach, profound constipation, the clay-colored stool on the one hand and on the other hand of the vomiting, the lienteric diarrhea and the bilious stool. Camon's experiment demonstrates the outpouring of adrenal secretion during fright, and Crile's induction of hyperthyroidism are now classical, and everyone is familiar with the cardiac excitation, respiratory disturbance, the sinking sensation of vasomotor paresis and asthenia, the forced urination produced by terror. The effects upon nutrition of such reactions as these must be very great, and indeed observation has already noted glycosuria among the effects of fear. So that it is inevitable that disturbances of protein metabolism must occur, which in some individuals are sufficient to fire the magazine required to produce a critical convulsion.

Thus, in emotion we are dealing not with a vague cause which cannot be analyzed, but with a definite reaction possible to express in terms strictly material. This shows emotion to be merely an accessory rather than an essential or primitive cause of epilepsy.

THE ROENTGEN RAY A DIAGNOSTIC FACTOR IN MYOSITIS OSSIFICANS CIRCUMSCRIPTA.*

By Charles A. Pfender, M. D.,

Washington, D. C.

Küttner has proposed the term myositis ossificans circumscripta for local muscle bone formation, not so much because he considered it etymologically correct as to differentiate this disease from a similar one universally designated myositis ossificans progressiva which is, however, as its name signifies, not local but progressive and general. The monograph by Herman Küttner is an inimically concise scientific study of myositis ossificans to which I render homage by quoting from it freely.

Up to 1909 there were 325 literature references bearing on the subject, and more than one hundred have appeared since then, but no uniformity of nomenclature. Cases have been reported as "muscle osteoma," "myosteoma," "osteoma intermusculare traumaticum," "parostal callus tumors," traumatic exostoses," "contusion exostoses" and others. These designations were merely reflections of the theories held by the authors as to the pathogenetic nature of the disease. In the light of our present knowledge of myositis ossificans I rather incline to the name suggested by Küttner and shall adhere to it in my discussion of the subject, leaving it for some one else to dignify the condition with a more correct name.

Etiologically myositis ossificans circumscripta may be divided into three groups: 1, Traumatic; 2, Nontraumatic; 3, Neurotic.

The traumatic group may be again subdivided into cases due to chronic or occupational traumatism, repeated severe traumatism and single severe traumatism.

Myositis ossificans due to chronic traumatism was very common among the soldiers of the German army at one time, the muscle most commonly involved being the inner third of the deltoid, the middle third next in order and the outer third of this muscle least. It was caused by a peculiar drill in which the gun was forced against the deltoid which in turn was forced against the coracoid process of the scapula, thus giving rise to an inflam-

* Read before the Medical Society March 17, 1915.

matory condition of the muscle with subsequent formation of bone. In a smaller number of cases the right pectoralis major was involved. This was probably due to the recoil of a gun when not correctly held against the shoulder when fired. The French in their publications spoke of this condition as the "Prussian disease." Since the abolition of this peculiar form of drill there has been a decided reduction in the number of cases. There still occurs what Küttner calls the "riding bone," a muscle bone formation in the adductor muscles of the thigh, particularly in the adductor longus muscle.

Similar muscle bone formation has thus been observed in saddlemakers, shoemakers and filemakers. The use of their various instruments necessitates a certain position thus giving rise to a chronic occupational traumatism which Virchow chose to designate "ossapraepubica." Beer drivers develop a traumatic muscle bone formation of the quadriceps extensor muscle caused by allowing beer kegs to fall from the wagon on the thigh while unloading.

Repeated severe, but not chronic, traumatism plays a part in the "bayonet bone" development. The typical fencing position exposes the left upper arm and left thigh to injury, and the bone develops within two to four weeks after one or more charges. Similar results have been observed to follow repeated gymnastic exercises by unskilled persons. We gain some idea of the frequency of repeated injury as a factor in the production of myositis ossificans from a military statistic of Schulz, who found among 296 cases, in which the cause could be elicited, 64 cases in which repeated severe traumatism was the causative agent.

The greater number of cases, however, are caused by a single injury, and usually by a blunt force. In military life Schulz found this to be the case in 232 out of 296 cases. The main factors were the bayonet and kick or bite by a horse. In addition to these direct injuries indirect injuries are also noted, such as sprains, rupture of a muscle sustained during a fall or while jumping, or upon being hurled to the ground in some unexpected manner.

In civil life direct and indirect injury both play a part, and the most common direct injuries recorded are horse kick, striking against the corner of a table, or boards, or heavy sacks, or weights and the like, while under indirect injuries, sprains, muscle strain and rupture of muscle tissue during gymnastic exercises predominate. Bone formation has been observed subsequently to a bruise obtained during a football game, and Küttner observed myositis ossificans in the muscles of the calf of the leg due to an unskilled movement while the patient was engaged in the game of tennis.

Röpke and Rubisch report three cases of myositis ossificans in which the genetic factor was traced to stretching of the abdominal muscles during laparotomy.

The literature also contains five cases where a sharp trauma was the cause of the abnormal bone development. A case of punctured wound with a knitting needle, one case of incised wound with a piece of glass, two cases of knife cuts, and one of knife stab are reported.

Dislocations play an important part in the production of bone in the tissues. The brachialis anticus is most commonly involved following posterior dislocation of the bones of the forearm. Cahier has compiled 56 cases, and out of these 16 showed extension into the elbowjoint capsule from which, as you know, some fibers of the brachialis anticus arise. In order to remove these bony growths it was imperative to open the joint before this could be accomplished. The biceps, triceps, subclavius, subscapularis and trapezius muscles have also been reported involved in the ossifying process.

Nontraumatic forms of myositis ossificans, cases where injury can be ruled out as an etiological factor, are comparatively rare. Küttner has collected only 12 cases of this group. The location is usually in the thigh and upper arm musculature. The tenets of the third classification, the neurotic form, may not prove acceptable to neurologists, but Wilms, Borchard and others have shown that certain diseases of the spinal cord, such as spina bifida, tabes dorsalis, syringomyelia, transverse myelitis, paralytic dementia and others are a factor in the genesis of muscle osteomas and probably justify the subdivision of neurotic myositis ossificans.

In the neurotic type of muscle ossification involvement of the musculature of the joints predominates. Strange to say, the psoas muscle which is so well protected and so rarely subjected to injury, is quite often involved in nontraumatic cases and in cases suffering from affections of the nervous system.

The traumatic, and the nontraumatic cases as well, occur during the early and middle life. That the former should occur during the active stage of life is to be anticipated. Why the nontraumatic cases occur during this period is hard to say. However, only a few cases have been reported, certainly not enough to justify any final conclusions as to the age incidence. The neurotic cases are most commonly met with in persons over forty.

Males predominate in cases of traumatic origin. Strauss has collected 127 cases, among which were only two females, and these, he says, were Amazonian in type. In nontraumatic, however, three out of eight occurred in females. In the neurotic form males occupy by far the greater proportion, corresponding somewhat to the frequency of syphilitic tabes and paresis in men.

In nontraumatic growth of bone in muscle tissue symptoms may be entirely absent, and in neurotic forms the primary nervous disease usually overshadows all else. In the traumatic form,

however, we usually have a history of contusion or muscle rupture. This may be associated or followed by local pain and swelling and an increased tenseness or induration of the part affected, due to the development of a hematoma. This inflammatory stage gradually subsides and is followed by a period of improvement. The first subjective sign that next arises is the patient's consciousness of weakness of the involved extremity. It is during this stage that the development of muscle bone is going on, and the latter is directly proportional to the lack of absorption of the hematoma. There is a tendency for the pain to return, but it is usually less intense than was the case at the time of injury. In those cases, however, in which the process of ossification exerts pressure on a nerve or blood vessel the pain will be much more intense, and this fact will frequently lead to an erroneous diagnosis of synovitis, bursitis, neuralgia, rheumatism, syphilis and the like. It is well to bear in mind that this bony myositis may develop within a week, as was shown by a case observed by Oriou where the tumor was so firm on the eighth day of the injury that an attempt to penetrate it with a needle failed. Although quite a number of cases develop within two to four weeks *post traumaticum*, the duration is usually longer. The majority of these growths are probably connected with the skeletal bone, but a not inconsiderable number occur where bone is not contiguous and where the muscle tumor is not even remotely associated with normal bone structure; in abdominal musculature, for example.

In the presence of symptoms as outlined above, and a traumatic anamnesis, one should not fail to consider the possibility of myositis ossificans. A number of cases were not diagnosed by clinical means for the simple and sufficient reason that this condition received no consideration whatever. In the neurotic cases the diagnosis was usually made quite by accident, the nervous symptoms overshadowing the secondary manifestations. Acupuncture has been resorted to, but of late the most valuable technical aid in diagnosis has been the Roentgen ray.

The Roentgen shadow varies with the degree of development of the growth. In the first few weeks of the transformation the shadow will be light and filmy in appearance, very much like recent callus, not homogeneous, but presenting lighter and darker areas. When the condition is more advanced ossification of the growth is manifested by a denser shadow and the lighter and darker areas assume a more or less linear arrangement, the general direction corresponding to the course of the muscle fibers. After complete ossification has been attained the process remains stationary for a while, permanently so in some instances and, although Roentgen examination may not disclose any connection of the growth with the bony skeleton, this may exist, but is probably composed of a more porous junction which may offer

no resistance to the ray. Occasionally the bone shadow shows a light center which may be due to a cystic cavity or to a connective tissue or cartilaginous nucleus.

In the differential diagnosis multiple progressive myositis ossificans must be considered. The occurrence of this disease during childhood, the tendency to begin in the muscles of the back and neck, and the involvement of entire groups of muscles differentiate it from circumscribed myositis ossificans. Hematoma may give rise to considerable diagnostic difficulty when myositis ossificans is preceded by hematoma. Muscle syphilis may be excluded by the history, course and result of specific therapy. Iodipin injections have given shadows which were interpreted as due to myositis ossificans. The differentiation of periosteal sarcoma of bone from myositis ossificans may prove exceedingly difficult. The pathogenetic factor may be the same in both, namely, a single severe traumatism ; both occur most commonly in young individuals. The period or time of development may coincide, both being capable of very rapid growth and both arise occasionally directly from a primary hematoma. The consistency of both differs very little. Sarcoma as a rule shows a preference for the epiphyseal regions of the long bones, while myositis ossificans is usually found along the diaphysis, but exceptions are noted. Here again the Roentgen ray examination proves its value by establishing the correct diagnosis. A sarcoma will reveal a spindle-shaped shadow, and the shape and tracing of the shadows differ widely in the two diseases. When the condition is advanced, myositis ossificans remains stationary while sarcoma progresses rapidly. A diagnosis, however, should be reached long before this period.

Cartilaginous exostoses or pieces of calcified floating cartilage usually occur in the vicinity of joints and are usually multiple. Areas of intratendinous ossification must be taken into consideration in the differential diagnosis. These usually occur in old persons, in the calcaneus and tendon of Achilles and are usually bilateral. Chronic inflammatory bone diseases, such as sclerotic osteomyelitis, tuberculosis and syphilis may be recognized by their clinical picture; in questionable cases the Roentgen examination will remove all doubt.

From the study of the material compiled, Küttner formulates the following conclusions as to the course and prognosis of myositis ossificans circumscripta. The growth may attain its maximum in a relatively short time and may remain so for many years or always ; or, the growth may attain its maximum in a relatively short time and then undergo spontaneous regression after a few months. Connection with skeletal bone makes the prognosis more favorable; the greater the muscle injury the slower the recovery. The tendency to spontaneous recovery, however, is quite pronounced.

The pathology of myositis ossificans I must defer to some more

convenient date. I should like to touch briefly on the treatment of this condition.

Treatment may be divided into prophylactic, conservative and surgical, depending on the duration and development of the lesion. In case of injury to the quadriceps extensor muscle or in case of posterior dislocation of the forearm it might be well to anticipate the possibility of a subsequent ossifying process. Some authors have recommended that the hematoma be aspirated and thus the development of bone prevented. Such a procedure does not seem practical. In case of an infiltrating contusion it would be difficult to remove much blood, and removal of blood from a fluctuating hematoma offers no assurance that bone formative elements will not be retained or quickly reformed and a myositis ossificans develop just the same. Such a procedure is therefore merely mentioned to be rejected.

In recent cases of posterior dislocation of the forearm it would be advisable, in view of the fact that myositis ossificans has been observed repeatedly in cases of classical reduction of the dislocation, namely, hyperextension, to resort, as a prophylactic measure, to simple extension or traction on the forearm. There is little likelihood of injury to the Brachialis Anticus muscle in such a procedure, and the number of associated cases of ossification would no doubt be reduced should the less drastic measure be resorted to. Forcible flexion exerts additional pressure on the already injured brachialis muscle and predisposes to subsequent ossification.

Conservative measures are indicated in the course of development of bone, such as rest, elevation of extremity, hydrotherapeusis, compresses, etc. Massage is contraindicated. Moderate movement should be encouraged, but any great exertion restricted. Practically all cases that come to the Roentgenologist are fully developed. The bone has been well formed, and the case is usually brought for diagnosis at a late stage, and in many cases upon suggestion of the patient, who is anxious to be relieved of the discomfort and pain due to pressure on nerves or blood vessels.

In the fully developed cases conservative treatment is the method of choice. A resumé of hundreds of cases reported in the literature leads to the conclusion that operative procedure and removal of the bone is indicated only in those cases where the growth gives rise to much subjective suffering or interferes with motility and where no improvement occurs after several months of conservative treatment. A statistic by Hans Schulz shows among 99 soldiers operated on during a period of ten years, 26 or 26.2 per cent. retired from active service on account of disability, while among 313 cases treated conservatively only 52 or 16.6 per cent. were retired for the same reason. When surgical procedure has been decided upon radical dissection of tumor and

surrounding periosteal tissue should be insisted upon, for unless this is thoroughly done recurrence usually follows.

In conclusion I should like to report a case of myositis ossificans which was referred for diagnosis by Dr. Gunning, on February 8, 1914.

Mrs. H., white, aged 31, on October 8, 1912, was sitting on the front seat of an ambulance when the latter was struck by a street car. She was hurled backwards into the ambulance, striking her right shoulder against the stretcher with terrific force. She sustained extensive contusions of the upper arm and shoulder, as may be readily seen from the photograph, and which was taken a few days after the injury. She suffered great pain for several weeks, after which the pain and contusion abated considerably, but did not disappear entirely. In about a year the shoulder pain grew more and more severe. The attending physican called in consultants of renown, one of whom decided finally that the condition was due to a bursitis and recommended operation, which was declined. The swelling and pain grew more and more pronounced as time went on, and, finally, upon suggestion by the railway surgeon, a Roentgen examination was made. On February 18, 1914, I examined both shoulders and found a well-developed piece of bone in the posterior and outer portion of the deltoid muscle of the right arm. It measured three and one-half inches in length, three-fourths of an inch wide and was apparently about three-eighths of an inch thick. The structure of the foreign body—if one may so designate it—ran parallel with the muscle fibers of the deltoid and showed light and dark areas corresponding either to cystic cavities or cartilaginous or connective tissue nuclei.

A settlement was effected with the railway company and the case was kept under observation by the family physician who continued simple local and general treatment. I had occasion to visit the patient recently and found her much improved, but suffering considerably at times from neuralgic seizures in the shoulder. The movements of the arm were also considerably restricted by the presence of the growth. She experienced great difficulty, for instance, in raising her arm to comb her hair or to fasten her dress. The tumor appears to be growing smaller and the induration of the surrounding tissues is greatly diminished. The musculature of this woman is ample and firm, so that it was impossible to verify by palpation the presence of any foreign body, either before or after the Roentgen examination was made.

On March 16, 1915, just about a year after the first Roentgen examination, I again examined the shoulder and noted from the plates that almost the entire growth had disappeared, leaving only a faint, irregular shadow not more than an inch in length and about the thickness of the lead of a pencil. Almost complete

Fig. 1.—Roentgenogram Showing Osseous Shadow in Deltoid Muscle.

absorption had occurred during the year, and spontaneous recovery should be complete within a few months.

Dr. Lemon presented a skiagraph of a similar case of traumatic bone formation. There was in this case an injury of the quadriceps femoris, followed by a tumor deep in the thigh and evidently attached to the femur. He had made the diagnosis of myositis ossificans. He had, however, seen the patient only once and knew nothing of his subsequent history.

Dr. Glushak said with reference to the etiology of myositis ossificans that Sir William McEwan's theory of bone formation might have weight; that bone is formed only when osteoblasts are present in the tissues. In rider's bone it may be shown that bone formation occurs in a slender line running down from the abductor insertion in the pubic bone, the necessary osteoblasts having been derived from the pubic bone. The cases here presented show that the new growth of bone has occurred only where the underlying bone has also been injured.

Dr. Paul Johnson said that Dr. Pfender's case recalled the recent address of Dr. Brickner, of New York, on subdeltoid bursitis. Might not Dr. Pfender's case belong in the same category as those presented by Dr. Brickner?

Dr. Macatee said that it would seem, whether one accepts the pathological theory advanced by Dr. Pfender that the new bone is formed from histological elements in the hematoma resulting from injury of muscle masses, or whether the theory of Sir Wm. McEwan as expressed by Dr. Glushak be adopted, that the inflammatory reaction in the muscles had nothing to do with the tumor formation and the name myositis ossificans is misleading.

Dr. Pfender said that there is no doubt that myositis ossificans as a designation for this condition is a misnomer; he had made that statement in the paper. With reference to the origin of tumors of the type described in the paper, it has been proved without doubt that new bone may be formed without any connection with the skeletal bones whatever; for example, one may call attention again to those instances of myositis ossificans occurring in the abdominal wall.

The position of the subdeltoid bursa would have to be taken into account in order to distinguish between subdeltoid bursitis with calcification and myositis ossificans of this region.

A Paradoxical Reply.—"Doctor, do you think eye-glasses will alter my appearance?" inquired Mrs. Gunson anxiously.

"I shall at least expect them to improve your looks," replied the physician.—*Lippincott's.*

UNUSUAL CASE OF FOREIGN BODY IN THE APPENDIX.*

By L. H. Reichelderfer, M. D.,

Washington, D. C.

M. G., single, colored woman, age 20; entered Garfield Hospital October 11, 1914, complaining of vague pain in the lower abdomen, and was admitted to the gynecological service of Dr. Miller. Her family history was negative, except that her mother died at 30 of tuberculosis.

January 1, 1914, she accidentally swallowed a small, straight pin; some weeks later she was admitted to the Washington Asylum Hospital because of abdominal pain, and in view of the history of the swallowed pin she was sent to the Army Medical School for an x-ray picture which showed the pin in an upper coil of the small intestine. She improved and left the hospital. During the summer she swallowed three other pins, one of which she remembers was bent, the one recovered later at operation. For three months prior to her entering Garfield Hospital she complained of dull, dragging abdominal pains, more marked on the right side; her appetite was poor, but there was no loss of weight; there was obstinate constipation, the bowels moving once in five or seven days. There was some cough; temperature, pulse and respiration were normal.

Dr. Miller found nothing abnormal in the pelvis; physical examination and x-ray plates of the chest were normal. A picture of the abdomen taken by Dr. Merrill showed distinctly a bent pin in the region of the ileo-caecal valve. The constipation became worse; a diagnosis was made of partial intestinal obstruction, probably due to local peritonitis produced by the pin, and she was referred to the surgical service for operation which was performed November 3, 1914.

Upon opening the abdomen a diffuse tubercular peritonitis was seen, both visceral and parietal peritoneum of the lower abdomen being covered with discrete tubercles; there were no adhesions or fluid, the process evidently being of recent origin, though no primary focus could be determined. There was no inflammatory reaction nor adhesions to point to the location of the pin, search for which was made difficult by the presence of tubercular nodules and the thickening everywhere present. The pin was finally located in the tip of the appendix, which was quite normal in appearance and without adhesions. The appendix was removed and the abdomen closed. The pin was bent in the shape of a letter U, the head and point being one-eighth inch apart.

The patient made a good recovery, though the constipation,

*Reported with specimen to the Medical Society March 31, 1915.

evidently due to the tubercular peritonitis and not to the pin, still persisted up to her discharge from the hospital. Five months later she is in good general condition, suffers no pain and is less constipated. An effort will be made to estimate the effect, if any, which the laparotomy may have upon the tubercular peritonitis.

Dr. J. F. Mitchell said that the case was especially interesting to him because in 1898, when with Dr. Howard Kelly, they had opened an appendix abscess and several days later while dressing the wound had found a rusty pin in the discharge. A study of the literature instead of confirming this as a unique case disclosed a great number of cases of foreign bodies of various kinds in the appendix (some figures indicating that such bodies may be found in about 7 per cent. of cases of appendicitis), and in that search he had found 62 cases of pin in the appendix in literature in 1898. He had reached the conclusion that pins constitute the majority of foreign bodies which lodge in the appendix.

Dr. Bowen had assisted Dr. Taber Johnson about fifteen years ago to remove an appendix in which a pin was found when examined after the operation.

Dr. Balloch cited the following case: A boy with symptoms of appendicitis was operated upon; the appendix appeared to be normal, except at the tip where it was adherent to the mesentery; in the adhesion was an abscess with a pin in its cavity.

Dr. A. B. Hooe was interested in the tuberculous peritonitis feature of Dr. Reichelderfer's case. Dr. Hooe had operated on a young woman for an appendix abscess, and a fecal fistula unfortunately resulted. As a secondary operation, to close the fistula, it was found that tuberculous peritonitis existed; he concluded the operation with every expectation of failing to secure closure of the fistula, and of ultimate death of the patient. On the contrary, she got entirely well.

Dr. Jack cited the case of a boy, ten years of age, who was operated on when extremely ill with an old peritonitis; a gangrenous appendix in which was a pin was removed. The boy unexpectedly recovered. As to tuberculous peritonitis, Dr. Jack had opened such a case and subsequently the patient recovered, got married and had two children.

Dr. Boveé reported two cases of gallstones in the appendix: one of stem and particles of a raspberry in the appendix, and three of bird shot in the appendix. He thought we should go slow in attributing the improvement of tuberculous peritonitis to the fact that the abdomen has been opened; tuberculosis in the peritoneum may recover spontaneously, just as tuberculous processes elsewhere do. He had opened the abdomen in a case in which was found tuberculosis of the tubes and peritoneum, so extensively adherent that the operation was abandoned. Yet this woman got well and married. In another woman, the uterus and appendages

were removed; the woman was subsequently extremely ill with tuberculous peritonitis, fecal fistula, etc. Yet she eventually recovered, the use of tuberculin apparently contributing to her recovery.

Dr. Reichelderfer said that his patient had confessed to a predilection for swallowing pins and other foreign bodies, but as the skiagraphs in the case disclosed only the pin found in the appendix the other objects had evidently passed uneventfully.

TWO CASES OF ULCER OF THE STOMACH.*

By Charles S. White, M. D.,

Washington, D. C.

The two cases of ulcer of the stomach which we wish to report invite your interest not from the standpoint of the unusual, obscurity of diagnosis, or final result, but chiefly because both cases are clear cut and almost typical in many particulars.

Case 1.—(History furnished by Dr. Wm. Gerry Morgan.) Mr. M., age 75, married and the father of twelve children; does not use tobacco or alcohol. The present illness has persisted off and on for two years. Symptoms: Acute agonizing pain in the stomach, coming on immediately after meals and lasting for hours; is worse at night, continuing intermittently until morning. Now and then has blood in feces. Appetite excessive, bowels constipated.

Physical examination: Teeth consist of a few roots with pyorrhea. Heart: apex beat seen and felt in the sixth interspace in nipple line; no marked accentuation of any of the valves; no other evidence of abnormality. Lungs normal. Kidneys not palpable. Radial arteries tortuous and firm. Liver and spleen apparently normal. Abdomen: panniculus spare; belly markedly scaphoid, with prominent spines and arches; recti deficient; moderate tenderness on pressure over McBurney's point; a spot of considerable tenderness a little to right of navel. Examination of secretion of stomach showed the free HCl 50, total acidity 86; no blood; moderate amount of mucus. Blood examination was as follows: Hb. 52, r.b.c. 4,000,000, leucocytes 8,200; differential count normal. Urine contained a slight trace of albumen and several hyaline casts. Feces contained occult blood. Thread test showed two distinct stains and was bile stained.

X-ray examination: (Dr. A. C. Christie). Diagnosis of ulcer on lesser curvature based chiefly on shadow of protrusion of bismuth on this border of stomach.

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*Reported to the Medical Society March 31, 1915.

Operation January 9, 1915. Marked induration palpated on lesser curvature near pylorus. The depression of the ulcer was determined by invaginating the stomach wall. The entire ulcer was excised, the pylorus closed by mesenteric compression and suture, and a gastro-enterostomy done. He made a rapid recovery and two months after the operation seemed very well.

Report on specimen by Dr. J. R. Scott, U. S. Army Medical School: Pathological examination shows fibrous tissue with mononuclear round-celled infiltration. No gastric epithelium present. A bacteriological report by Sgt. Stimmel showed a pure culture of streptococcus.

Case 2.—(History furnished by Dr. Wm. Gerry Morgan.) Mrs. C., age 52. Family history negative. Past history: Typhoid at 8, appendectomy six years ago. Was said to have ulcer of the stomach one year ago. Present illness has lasted two years. Symptoms: Severe pain in stomach, coming on one or two hours after meals; occasional coffee-ground vomit; has a painful spot in dorsal region; appetite good. Physical examination: Heart and lungs, liver and spleen apparently normal. Kidneys not palpable, belly well formed; recti normal; no marked meteorism; very small well-healed scar extending upward one and one-half inches from symphysis. Moderate tenderness on pressure over upper half of belly generally, perhaps more marked just below right superior costal angle. Sense of definite resistance is felt over right half of epigastrium. No other points of tenderness. Splashing sound heard with difficulty, but apparently extends from mid-epigastrium to one inch below navel. Gastric secretion: Free HCl. 56, total acidity 66; no blood. Blood examination: Hg. 58, r.b.c. 4,280,000; leucocytes 10,400. Differential count normal. Urine normal. Feces normal and contained no blood. Thread was stained but apparently did not pass the pylorus.

According to Dr. Christie the x-ray showed evidence of pyloric obstruction with a small protuberance on the lesser curvature near the pylorus, like an ulcer; possibly malignant.

Operation January 27, 1915. Indurated and excavated ulcer on lesser curvature near pylorus; almost identical with Case 1. Same treatment as previous case.

Dr. Scott reports that the tissue is fibrous with intense infiltration with mononuclear round cells, especially in the floor of the ulcer. There is no mucosa in the section. There is no evidence of malignancy. The bacteriological examination by Sgt. Stimmel showed a pure culture of staphylococcus.

In both cases the absence of blood in the gastric secretion, the well-defined projection of bismuth in the plate, and the presence of organisms, are noteworthy features. It is not a radical hypothesis to assume that septic emboli were the origin in both instances, and it is possible that eventually the cause of gastric ulcer may be laid at the door of a septic process in even a remote

portion of the body. In Case 1 carious teeth and pyorrhea should not be disregarded in the etiology and may bear a very definite relation to the ulcer. It has been suggested that emboli from the lungs may be an unrecognized cause. This subject of infection naturally is associated with vaccines in the treatment, and we would say that we have used an autogenous vaccine in two perforating ulcers of the stomach, without sufficient reaction to call specific.

Dr. Verbrycke said that the cases were particularly interesting because they gave opportunity for the study of the behavior of these cases after excision of the ulcer. For some two years he had been more and more inclining to the theory of septic infarction as the main etiological factor in gastric ulcer. Rosenow, of Chicago, has studied a large series of cases from the Mayo clinic and has usually found streptococci in the excised ulcers; in his own cases, about 40, he had not always found streptococci, sometimes staphylococci alone were found. He has used autogenous vaccines with remarkably good results, especially in cases with recurrence after operation.

Dr. Verbrycke wished to add a word on excision of gastric ulcers; he had long regarded gastro-enterostomy as a mere surgical makeshift, unless for the relief of obstruction; but with insistence on the part of the gastrologist, surgeons are more and more excising ulcers, with no increase of mortality and with better terminal results.

CASE OF PAPILLOMATOUS CYST OF NIPPLE.*

By Edward A. Balloch, A. M., M. D.,

Washington, D. C.

H. M., 40 years of age, entered the hospital March 13, 1915, with the following history: Family and personal history unimportant. About February 15, 1915, patient noticed a small tumor below the right nipple, about the size of the end of a finger. It increased rapidly in size, and three weeks afterwards there was noticed a hemorrhage from the nipple to the amount of a tablespoonful, after which the mass lessened in size until it reached its present dimensions. No pain at any time and only a slight sense of discomfort in the breast.

Examination showed a cystic tumor 3 cm. in diameter, below right nipple. Tumor elastic, compressible and somewhat movable. No secretion when tumor was compressed. No glandular enlargement. Diagnosis, cyst of ampulla, with probable papilloma.

*Reported with specimen to the Medical Society March 24, 1915.

This diagnosis was based on the history of the case, the feel of the tumor and the fact of hemorrhage. Operation March 15. The cyst was excised and a frozen section immediately examined. The report being that the growth was non-malignant, the wound was closed, and healed without incident.

The importance of these cysts lies in the fact that they often form the starting point for malignant growths.

Dr. Simpson inquired whether the diagnosis of papilloma was made from a study of the histology or from the gross appearances of the specimen.

Dr. Balloch replied that the diagnosis was made on the basis of the microscopic appearances in frozen sections at the time of the operation.

ARTIFICIAL PNEUMOTHORAX IN PULMONARY TUBERCULOSIS WITH A REPORT OF CASES.*

By W. D. Tewksbury, M. D., Superintendent Tuberculosis Hospital,

Washington, D. C.

Artificial pneumothorax consists of the introduction of some gas, either nitrogen, oxygen or atmospheric air, into the pleural sac for the purpose of producing a collapse of a tuberculous lung, thereby putting that lung partially or absolutely at rest. The immobilization of tuberculous joints with plaster casts accomplishes beneficial results, and this same principle is involved when we immobilize a lung by compression with gas.

For almost a century past occasional reports appear in medical literature relative to improvement in tuberculous patients following collapse of the lung, due to effusion or accidental or spontaneous pneumothorax. In 1895 Forlanini reported the cure of an advanced unilateral case of pulmonary tuberculosis by artificial pneumothorax. In 1898 John B. Murphy, of Chicago, reported five cases treated with marked improvement, and under Dr. Murphy the work was continued by Lemke, Neff and others, in a total of over 460 cases with excellent results. Since 1898 artificial pneumothorax has been used extensively in Europe, and during the past four years it has been very generally adopted in tuberculosis institutions throughout the United States. Lapham, Robinson and Floyd, Hammon and Sloan, Webb, Lloyd and many others have recently reported cases with excellent results. Baldwin, of Saranac Lake, and Minor, of Asheville, speak favorably of the treatment in selected cases.

* Read before the Medical Society March 3, 1915.

Method.—The method usually used to induce a pneumothorax is comparatively simple. It consists, in short, of introducing a needle into the pleural sac, and allowing the gas to flow in under slight pressure. It is essential, however, that a manometer be used to indicate when we are in the pleural sac, and to show us when we have overcome the negative pressure and obtained a collapse of the lung. This method requires only some local anesthetic, such as cocaine or novacaine, and causes no pain to the patient.

Complications.—In my experience complications following the use of this method are rare. Those mentioned as occasionally occurring are hemorrhage, air embolism, infection, formation of fluid, recrudescence in the untreated lung, surgical emphysema, and spontaneous pneumothorax. Hemorrhage and air embolism are so rare that I will merely mention them in passing. Infection may occur from the outside through faulty technique or from the inside through allowing the needle to enter the lung and then drawing it back into the pleural sac bringing with it some organisms from the tubercular lung. This latter can be avoided by watching our manometer. Effusion has been reported in a considerable number of cases, but it usually causes no serious symptoms and is gradually absorbed without interference. A few cases have been reported where active trouble appeared on the untreated side, presumably from throwing too much work on the sound lung. This can usually be avoided by collapsing the affected lung gradually, and keeping the patient in bed until the sound lung has established compensation. Surgical emphysema sometimes occurs, and is due to the gas escaping from the thoracic cavity into the muscles of the chest. This can be avoided by using a small needle for introducing the gas. I have seen only two of the above-mentioned complications, namely, emphysema and spontaneous pneumothorax, and they will be referred to under report of cases.

Selection of Cases.—The selection of cases for artificial pneumothorax is at present rather difficult. First, it is essential that we select a patient who has one comparatively sound lung. A strictly unilateral case fulfils the ideal type, but a slight infiltration of the opposite lung is not a contraindication. Second, it is essential that we select a patient in whom the affected lung is not thoroughly bound down by pleuritic adhesions of long standing. I find that recent adhesions can be overcome, and a complete collapse eventually obtained, but in some cases it is impossible to find a free pleural sac on account of general dense adhesions. The question now arises, should all unilateral cases without dense adhesions be treated by pneumothorax, or only those patients who are becoming progressively worse? Murphy has advocated this treatment in early cases. In the "Surgical Clinics" of John B. Murphy, for December, 1913, he says: "The time for giving

this treatment is exactly the same as for treating surgical tuberculosis in any portion of the body, which means it should be begun in the earliest stages of the disease. The earlier the treatment is begun the better the prognosis." The majority of the work done in this country, however, has been among advanced cases which were becoming progressively worse. We do not yet know what will be the ultimate results in these cases. There is a difference of opinion as to whether the lung will again functionate after being collapsed for a year or more. In some cases it is found that the lung will not expand, in others the lung has expanded and displayed normal functionating powers after being collapsed for over a year.

I believe that in view of the great number of favorable results being obtained in these advanced unfavorable types the treatment should be used in suitable moderately advanced cases which continue to show some active symptoms after dietetic, hygienic treatment, even though these patients are not becoming progressively worse. In view of our present limited knowledge, I do not believe incipient cases should receive artificial pneumothorax until it has been conclusively demonstrated that they will not respond to the usual measures. Lapham, of North Carolina, reports 16 advanced unfavorable cases with 9 recoveries 6 uncertain but improved, and 1 death. This is 55 per cent. recoveries. Sloan, of Eudowood Sanitorium, Md., reports 12 far advanced unfavorable cases with 6 doing remarkably well, 3 retrogressing, and 3 dead. This is 50 per cent. marked improvement. Lyon, of Rutland, Mass., reports 2 incipient patients treated with an apparent cure in both cases. He reports 31 cases advanced unfavorable cases, with 15 either cured or progressing toward a cure, 15 in whom the treatment was discontinued for different reasons, and only 1 death. This is about 50 per cent. either cured or approaching a cure. Lloyd, of Catawba Sanitorium, Va., reports 17 progressive cases treated, with 14 improved, 2 unimproved, and 1 dead. This is 80 per cent. improvement. It was such reports as these from unprejudiced observers which influenced us to adopt this treatment, and the results obtained bear out fully the reports from other institutions. Of the 16 patients treated in our series 3 were found to be unsuitable on account of dense adhesions, leaving 13 to be reported on. In two of these cases the treatment was used simply to stop hemorrhage. Of the remaining 11, all were bilateral with the chief involvement in one lung. All were moderately or far advanced, and I wish to lay especial emphasis on the fact that in all cases the prognosis was unfavorable.

Case I.—Male, white, age 20, entered the Tuberculosis Hospital September 8, 1914, with history of having had tuberculosis about 6 months. Examination showed a dense infiltration of most of left lung, with slight trouble in right. Patient was kept under observation for about one month. The afternoon

temperature was from 100 to 101 degrees. He had considerable cough and expectoration both day and night, and showed no improvement on general treatment. November 5, 1914, one month after admission, an artificial pneumothorax of the left lung was induced by the introduction of 400 c.c. of air, and the lung has been kept compressed up to the present time by injections of air every two or three weeks. The temperature immediately returned to normal and has remained so. The cough and expectoration were diminished, and about three weeks after the first treatment ceased absolutely. This patient has gained 23 pounds, has had no cough or temperature for three months, and presents the picture of a cured case.

Case II.—Male, white, age 22, entered the hospital November 11, 1914. The patient had been under my care at the Tuberculosis Dispensary for two months and was becoming progressively worse. Marked involvement of left lung with cavities. Symptoms were chills, fever, sweats, cough and expectoration, and loss of weight. November 12, an artificial pneumothorax was induced and has been maintained up to the present time. The temperature has been normal, and the cough and expectoration very much reduced, but not absent. There has been a gain of twelve pounds in weight and, aside from a slight morning cough with expectoration, he presents the picture of a cured case.

Case III.—Female, white, age 23, referred to me by Dr. Lloyd, of Catawba Sanitorium, Va. Patient entered Catawba Sanitorium in May, 1914. Was confined to bed for about two months with afternoon temperature of 101 to 102 degrees, profuse cough and expectoration, and loss of weight. There was marked involvement of left lung, and slight involvement of right. August 12, 1914, her left lung was collapsed and she began immediately to improve. She returned to home in November, four months after her first treatment, as an arrested case. December 8 she came to me for an injection of air for the purpose of maintaining her pneumothorax. I have given her these treatments at an interval of three to four weeks since that time. She has had practically no fever, cough, or expectoration for six months, is living at home, and doing a moderate amount of housework without inconvenience.

Case IV.—Female, white, age 24, referred to me also from Virginia, by Dr. Lloyd. Her case is so nearly identical with Case III that I will simply mention that her right lung was collapsed March 12, 1913, and she has been living the life of a well-arrested case. I have lengthened the interval between her treatments to six or seven weeks, and am at the present time considering the advisability of discontinuing the injections and allowing her lung to gradually expand.

Case V.—Female, white, age 40, entered the hospital February 7, 1914; had a moderate involvement of the right lung with

slight involvement of left. For eleven months she ran an afternoon temperature of about 101 degrees, had a moderate cough, and showed no tendency to improve on general treatment. November 20, 1914, pneumothorax treatment was begun and has been continued up to the present time. The cough and expectoration have stopped, but the temperature, while reduced, has not returned to normal. This patient has been perceptibly improved, but on account of the amount of involvement in the untreated lung has not approached an arrestment of her trouble.

Case VI.—Female, white, age 28, entered the hospital Oct. 23, 1914. Examination showed marked involvement of right lung with cavity, also moderate involvement of left, with afternoon temperature of 101 to 102 degrees, excessive cough and expectoration. December 23, a partial pneumothorax was induced, resulting in much diminished cough and expectoration and a lower afternoon temperature. January 26, the patient, following an indiscretion in exercise, had a sudden pain in the treated side, followed by marked dyspnoea, severe dry cough, and all the signs of a severe shock. On examining the chest I found an open pneumothorax, with a complete collapse of the lung, due probably to the tearing away of an adhesion from the visceral pleura. She was very ill for two weeks, since which time she has gradually improved, and is at present running practically a normal temperature, and has very little cough and expectoration.

Cases VII and VIII.—Two colored males, with advanced lesions in right lung. Both have been on pneumothorax treatment for about two months. In both cases there has been a marked improvement in cough and expectoration, but no improvement in the temperature or general condition. In my opinion these patients are becoming gradually worse. The treatment has been in the nature of a palliative remedy, however, as it has relieved the distressing cough.

Case IX.—Female, colored, age 17, entered the hospital Jan. 16. Examination showed advanced lesion of right lung with cavity. Left lung moderately affected, afternoon temperature 102 degrees. January 27, a partial collapse of the right lung was induced, and the treatments have been continued up to the present time. No marked effect on the temperature has been noted, but the cough and expectoration have been considerably decreased. This patient is continuing to become progressively worse, the treatment acting merely as a palliative remedy in relieving cough and expectoration.

Case X.—Male, white, age 46. Patient of Drs. Franklin and Claytor, in Garfield Hospital. There was an advanced lesion of upper half of right lung, left lung practically normal, afternoon temperture 102 degrees. December 29 we started pneumothorax treatment. The temperature immediately began to come down, and now rarely goes above 100 degrees. The expectoration has been much diminished and the patient's general strength is improving.

In this case there has been an improvement, but no approach toward an arrestment of the trouble.

Case XI.—Male, white, age 37, came under my observation about Feb. 1, 1915. Advanced involvement of the right lung, slight involvement of left. Marked cough and expectoration, loss of weight, and afternoon temperature of 102 to 103 degrees. February 12, pneumothorax treatment was begun. The cough and expectoration have been much improved and the afternoon temperature is from normal to 100 degrees. This patient has perceptibly improved.

Case XII.—Female, colored, age 28. Entered hospital Dec. 24, 1914, having severe hemorrhages. Examination showed large cavity in right lung with bubbling and wheezing râles; left lung emphysematous, no râles present. December 29 the bleeding became so profuse that I induced a collapse of the right lung, using 1,200 c.c. of air. Hemorrhage stopped for twenty-four hours and then recurred. Dr. Claytor and I both felt that she would die unless something more was done, so December 30 we injected about 800 c.c. of air, in an effort to get a more complete collapse if possible. Patient died of the bleeding, however, and a post mortem was made. On opening the chest we found the right lung thoroughly collapsed backward and inward against the spine. On section we found a large cavity full of soft clots, with two bleeding points entering it. There was considerable consolidated tissue around this cavity, making its walls so firm that it could not possibly be collapsed without exerting more pressure than we could have exerted with air. This impressed upon us the fact that there is a certain type of hemorrhage in which the bleeding is from a cavity with thick walls that will not respond to pneumothorax treatment.

Case XIII.—Female, white, age 23, entered the hospital September 24, 1914. December 19 began to have severe hemorrhages which would not respond to the usual measures. December 21 we resorted to artificial pneumothorax, inducing a collapse of the right lung with 800 c.c. of air. The bleeding promptly stopped, and did not recur. This patient has had no more hemorrhages, has a normal temperature and is getting along nicely.

Summary.—In the 11 cases of our series, all with an unfavorable prognosis, 4, or 35 per cent., are approaching a complete arrestment of their trouble; 4, or 35 per cent., are improving, and only 3, or 30 per cent., are unimproved. In the 2 cases in which the treatment was used to stop hemorrhage it succeeded in 1 and failed in the other. The 9 white patients using this treatment have been benefitted, whereas it has been of no benefit in the 4 colored cases treated. Seventy per cent. of all patients treated have been improved, 30 per cent. unimproved.

Conclusion.—In artificial pneumothorax we have a treatment which is theoretically rational, and which in practice undoubtedly

gives excellent results in selected cases. Until we know more about the ultimate results of this treatment, however, it should be used only in the advanced stage, or in early cases failing to respond to general measures.

I wish to thank Drs. Claytor and Thomas for the privilege of using the cases on their services, and Dr. Pfender, who did the x-ray work.

Dr. Sloan expressed his appreciation of the excellent contribution to the literature of tuberculosis. Tuberculosis workers are normally pessimistic; they put on an outward appearance of optimism, but a doubt always exists as to the curability of tuberculosis. The mode of treatment described and advocated so conservatively by Dr. Tewksbury, seems, however, to have much of promise in it, because it rests on a sound physiologic principle, namely, rest of the affected part, together with the arrest or reduction of toxic absorption. Several points need to be considered, especially with regard to the limitations that should be put upon the application of the treatment. First of all the patient needs to be carefully selected; in the good lung there should be no lesion below the third rib if active; if inactive there should be no lesion below the fourth rib. The ideal case is the early unilateral case. A small basal lesion in the better lung is a contraindication for the treatment, for if rest is good for one lung, overwork is harmful for the other. There can be no doubt in the minds of those who have observed the application of the method, that by cautious and gradual compression of the worse lung, improvement can from day to day be observed. A class of cases which can be compressed with special benefit are those which have been repeatedly arrested only to relapse on returning to work. Incipient cases with early hemorrhage may also be treated in this manner; but ordinary incipient cases are not now subjected to this treatment. We do not yet know how the method finally acts; in the case of a bad lung this question does not greatly concern us; it may be much better that it should never expand again. Cases complicated by serious lesions elsewhere, such as of the larynx, of bones, of the intestines, or non-tuberculous complications, such as alcoholism or arteriosclerosis, are all eliminated as proper subjects for artificial pneumothorax. The introduction of the manometer made the treatment possible. Early workers in the method abandoned it as too dangerous; Murphy and Limke, notably, did valuable pioneer work, but gave it up after serious accidents; one could not be certain where the point of the needle was. Brauer, of Hamburg, tried the plan of making an incision down to the pleura and then introducing the needle; this procedure has, however, obvious disadvantages. In 1909 a Dane introduced the manometer which has proved to be a mainstay for this operation; it shows exactly where the needle is and thus is a factor of safety which gives the opera-

tion a legitimate status. The introduction of air is never begun until the oscillations in the manometer indicate that the needle point is free in the pleural cavity. The usual volume of air introduced at the first is 500 cc. Complications that have been noted are (1) pleural shock; (2) infection of pleural sac; (3) air embolism; (4) meningitis; (5) subcutaneous emphysema.

Repetition of treatment and the quantity of air used need to be determined by the course of individual cases, and thus the whole thing should be in experienced hands. Another point that is difficult of decision is when to discontinue the treatment entirely; here again one has to be guided by the sum of all the factors present in a given case. Repetition of treatment after a compressed lung is allowed to expand is impossible, because adhesions form and thus become an insuperable bar. It is often best on this account to keep the lung collapsed indefinitely. Hydrothorax had occurred in four cases in his own experience; this is not a bad complication and it accomplishes the same effect as the gas. In 43 cases in which this treatment has been used in Maryland, there have been 40 per cent. of good results.

Dr. J. D. Thomas could add nothing to what the previous speakers had already said. He desired to congratulate Dr. Tewksbury on the results of his work and upon the excellent judgment shown in his selection of cases. This is a most important feature of the work; otherwise a black-eye may be dealt to an otherwise good method of treatment. He was glad to hear both speakers pronounce against the application of the treatment in incipient cases, because the method has no advantages over other accepted methods of treatment in this class of cases. Nature should always be given a full chance. It seemed to him that some doubt may still be entertained as to the wisdom of putting a lung out of commission when it is known that there is any lesion at all in the opposite lung. It is interesting to speculate upon what is the rationale of the improvement following this treatment; it must be due to the effective drainage of cavities.

Dr. Ramsburgh related the history of two cases in his hands which had been treated in this manner. He emphasized also the opinion that compression should not be used in incipient cases; he regarded it as very beneficial, however, in selected cases. He called attention also to the importance of a radiographic diagnosis before applying the treatment.

Dr. Randolph commented upon the simplicity of the apparatus employed by Dr. Tewksbury and upon the clear and satisfactory demonstration of it. We should congratulate ourselves on having such a valuable series of cases demonstrated here.

Dr. Kober said that it seemed proper for him to express his appreciation of the work of Drs. Tewksbury and Sloan. We are fortunate in having the work in such conscientious and scientific

hands; he hoped that future experience would bear out the conclusions reached in the paper.

Dr. Tewksbury expressed his appreciation of the generous remarks made in the discussion of his paper.

A CASE OF PERIDIVERTICULITIS.*

By A. L. Stavely, A. M., M. D.,

Washington, D. C.

A case a little out of the ordinary came under my care a few weeks ago and its features were such that I thought its presentation before this Society with a brief consideration of the disease as a whole might be of some interest.

Mrs. M., age 74, was seen by me Feb. 2, 1915, in consultation with Dr. Macatee on account of a pelvic tumor. Her general condition was excellent and, aside from a vague feeling of discomfort in the pelvis and a certain indisposition to continue her work, for she was a government employee, there was nothing to suggest any disorder. Dr. Macatee had examined her two or three years before and had found no evidence of pelvic trouble. A vaginal examination revealed a small senile uterus and a slightly movable tumor, the size of an egg and sensitive to the touch, situated on the left side.

A tentative diagnosis of solid tumor of the ovary was made and operation recommended. On Feb. 3 the abdomen was opened and, instead of an ovarian growth, I found an involvement of the lower part of the sigmoid, resembling so closely a malignant stricture, that a resection and an end-to-end anastomosis were done. Appreciating the difficulty of securing a safe approximation by this method I tried to unite laterally. This was rendered impossible on account of the difficulty of working down in the pelvis.

Protection against leakage was secured by the insertion of a cigarette drain. For two days following the operation she had occasional vomiting of small quantities of brownish fluid and for a while longer had some pain in the lower abdomen, which required the use of an opiate. There was some irritability of the bladder. Her pulse was excellent, never crossing 100, and her temperature only once reached 100.5. The abdomen remained soft and there was unusual freedom from gas. On the fifth day some liquid feces appeared on the dressing. This was in evidence for the greater part of two weeks, after which it gave her no trouble. At the present time a little appears sometimes when

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she has a bowel movement. She was kept on thin diet and the rectum irrigated daily with satisfactory results.

I have confessed to one mistake in diagnosis. Now I wish to confess another. After the removal of the segment of bowel it was opened longitudinally and no evidence of cancer was found. It proved instead to be a case of peridiverticulitis. One diverticulum, which was the cause of the soreness, contained an inspissated concretion and pus. While I admit to two mistakes in diagnosis in one patient, I have the uncertain satisfaction of knowing that others have done equally badly.

The following pathological report was furnished by Dr. J. B. Nichols: "The walls of the bowel (submucous, muscular and subperitoneal) are densely infiltrated with small round cells and polymorpho-nuclear leucocytes—inflammatory. There is an increase caused by fibroblastic (almost myxofibroblastic) proliferation of the fibrous tissues, mixed with these subperitoneal fatty masses; in places these subperitoneal tissues also show small-celled infiltration and at one place there is slight necrosis. Nothing malignant is seen."

Aside from the purely scientific side of medicine there seems to be nothing, no matter how seemingly new or obscure, that some old investigator, like Rokitansky, has not either accurately portrayed it or suggested its possibility. So it is with our subject tonight.

Virchow, in 1853, was probably the first to call attention to this disease, describing it as a circumscribed adhesive peritonitis, but not recognizing the etiological relation to diverticula. Graser, in 1898, cleared up the matter and since then others, especially the Mayos and their assistants, have given it a well defined position as a surgical lesion of much importance.

Diverticula may occur at any part of the gastrointestinal tract, but they are much more common in the large bowel, being found much more often in the lower part of the sigmoid and after that in the cecum and the appendix. They may be single or multiple. In some sigmoids they may be found by the scores. They may be true or false. The true include all the layers of the intestinal wall; the false are formed by the protrusion of the mucosa and the submucosa through the muscular layer, having as their outer covering the peritoneum. These are much more common than the true diverticula. They vary in size from the smallest point to that of a hazelnut, rarely larger. They are usually about the size of a pea. While occurring at any point of the circumference of the bowel, they are more common at the mesenteric side, though many have been found in the fat of the epiploic appendages. In their early stages they may be elongated, but as they enlarge they become more nearly oval or flask shaped. The opening of the diverticulum is nearly always smaller than the largest diameter of the sac; sometimes it is quite constricted. They may be sessile

or pedunculated. They contain fecal masses like the concretions so common in the appendix, and these can often be seen through the openings and squeezed out into the intestinal canal.

The age incidence is rather late, most of them occurring or coming to operation in the sixth decade. True diverticula may be congenital or acquired. The false diverticula have a varied etiology. Old age is a factor. It is rather interesting to know that they occur usually in persons of good health, who possess an unusual amount of fat. Bland Sutton has shown that the fat in the submucosa is continuous with that in the epiploic tabs, and he believes it exerts a direct influence in producing these little herniae. It seems clear, too, that the epiploic fat has a direct relationship to the entrance of the bloodvessels through the intestinal wall, and wherever a bloodvessel enters, there is a point of lessened resistance. It is probable that both are factors. There is a weakness of the intestinal wall, which may be congenital or the result of debilitating diseases or old age. A potent cause is increase of pressure within the bowel, such as we get with constipation and excessive gas formation.

There is no question that diverticula exist without causing symptoms, and it is only now and then that trouble ensues. The active cause for harm is the continued retention of inspissated fecal matter. This is rich in bacteria and acts also as a mechanical irritant. Infection and gangrene may develop in the pocket or abscess form. Perforation may occur. The distension of the sacs is sometimes so great that they become very much thinned and permit easy passage of bacteria and their toxins. This results in an extensive localized infiltration of the submucous and peritoneal layers, with subsequent contraction and stricture formation. To this is given the name peridiverticulitis. With the presence of an infectious agent so near the peritoneal cavity we may have a number of results, which are most natural and which may only be mentioned: General peritonitis, the chronic localized inflammation already referred to, abscesses, adhesions between the sigmoid and other parts, fistulae, especially with the bladder, fistulae in the wall of the bowel itself, chronic inflammation of the meso-sigmoid and development of carcinoma.

Without wishing to prolong the subject too much it might be well to refer more particularly to the chronic inflammatory process and its relation to carcinoma. The proliferation of fibrous tissue is sometimes very extensive. It may involve from one to eight inches of the bowel. When a considerable length of bowel is involved a number of diverticula are affected, and those included in this area are contracted and narrowed and often hard to find. The wall may become thickened to as much as two inches and the inevitable result is stricture and gradual obstruction. In this inflammatory process islets of mucous membrane are sometimes inverted and enclosed, forming a suitable nidus

for the formation of cancer. The Mayos have carefully studied the relations of peridiverticulitis to carcinoma, and have not only demonstrated the relationship, but have demonstrated the alarming frequency of malignant disease in this connection. McGrath in the Mayo Staff Papers, 1912, reports 27 cases, which have been operated on at Rochester. All these had marked inflammatory changes, a mass was present, they were evidently very chronic, and in 7, or 25.9 per cent., cancer was present.

As has been said, diverticula may exist without symptoms. It is only when inflammatory reaction has taken place that they develop. As is evident from the character of the pathology, the symptoms in the acute form would be much like those of appendicitis, and it has often been diagnosed as that disease. We have here inflammation, abscess formation, gangrene and rupture of the diverticulum, peritoneal adhesions, various kinds of fistulae, especially those involving the bladder, and the symptoms will vary according to the nature of the process.

With the infiltrating form we have in time a mass, which will be ordinarily palpable and generally movable and a gradually increasing obstruction of the bowels. When peridiverticulitis occurs in a woman the mass can often be detected by vaginal examination, as in my case. There is a certain sensitiveness about it which is not ordinarily evident in other tumors.

The first case of the Mayos was treated in 1896; but was not then identified as diverticulitis. The following is a brief description: "A well-nourished man, 51 years of age, presented himself on account of fistula into the bladder. Some months before he developed, pain soreness and tumefaction in the left inguinal region; after several weeks' illness a large amount of foul pus discharged through the bladder. The tumor disappeared, but pus, gas and feces continually appeared in the bladder. A diagnosis of appendiceal abscess was made. Upon opening the abdomen the appendix was found to be normal, but there was a sausage-shaped tumor imbedded in adhesions and a fistula connecting the sigmoid with the bladder. The fistula was divided and the openings closed; but primary union was not obtained, and urine and feces discharged freely through the abdominal wound. The bladder opening healed; but two years later the fecal fistula was still in evidence."

About ten years ago I discovered a false diverticulum the size of a pea situated in the appendix. Never having seen one before, it occurred to me to ask Dr. John B. Deaver about it, and he said it was entirely new to him.

It is safe to say that an exact preoperative diagnosis in either the acute or chronic form is seldom made. In the latter the presumptive evidence from the clinical history and the physical examination will sometimes lead us in the right direction. Protracted chronicity of symptoms associated with a tumor of the

lower bowel and x-ray pictures showing the injected diverticula will make a diagnosis of peridiverticulitis certain. The x-ray can not be depended upon with certainty in every case; but it has positively more than once been used with absolute satisfaction. A differentiation, too, will have to be made from appendicitis, from inflammatory processes involving the left side, various tumors in the sigmoid or outside of it, and strictures from cancer, tuberculosis and syphilis. Even after actual inspection it is frequently impossible to differentiate it from cancer, unless diverticula are found nearby, and even if they are found we cannot be sure that cancer is not engrafted on the process. Blood in the stools is seldom found and if present would suggest carcinoma. Little help can be expected from the sigmoidoscope. The microscope in the end may have to be called in to reach a definite conclusion.

Treatment is operative and will depend somewhat upon the condition found. Abscesses and peritonitis may make it necessary to defer radical measures until a more favorable time. Mayo mentions the anastomosis of the small bowel with the large as a means of keeping the feces liquid and preventing the formation of concretions. The proper procedure is some form of resection. Under favorable circumstances this may be undertaken at once, and will consist of an end-to-end or lateral anastomosis. The first is more serious on account of the difficulty of securing good union.

The plan of slightly invaginating the anastomosis and passing in a rectal tube will improve results. If the involved bowel is sufficiently movable it may be brought outside the body, later cut off and the continuity of the bowel established by clamping the two opposing cylinders. As an extra precaution, Bloodgood recommends an end-to-end, side-to-side anastomosis with the attachment of these ends to the abdominal wound so that an opening may be made, if necessary.

Dr. Macatee said that the etiologic theory of increased intra-intestinal pressure as an explanation of the development of diverticula of the type seen in this case was not borne out by the bowel habits of the patient; so far from being habitually constipated she was, as a matter of fact, so unusually normal with respect to the bowel function that a lesion of the intestinal canal was not suspected at all. Her present condition is satisfactory in every respect; there is only the merest trace of her fistula exuding a little serous matter; there has been no trace of fecal material for weeks. The whole course of her postoperative history attests the high character of surgical skill with which Dr. Stavely conducted the case.

Dr. Jack said that the case brings up the old question of the danger of end-to-end anastomosis of the large intestine. It had

been his experience that with the Kerr-Parker stitch and the Connell suture it is possible to get entirely satisfactory results with this form of union; he has now had six such cases, all of which had a satisfactory outcome.

CASE OF PLASTIC OPERATION.*

By Leon A. Martel, M. D.,

Washington, D. C.

The case which I am pleased to report tonight was referred to my service at the Washington Asylum Hospital. It is one which I think is exceptionally rare because of the extensive destruction of the entire pelvic floor during childbirth and because of the severe injury to the anterior bladder wall.

Sarah L., colored, age 36, widow, domestic; has resided in the District of Columbia about one year; has had two children, both of whom were very large, causing long, tedious labors, but without the use of instruments. She was attended both times by midwives. She states that she was quite badly torn at the first labor and that she never healed. She was also badly torn by her second baby, eight years ago, at which time she suffered from a complete tear into the rectum followed by incontinence of urine and feces, prolapse of the rectum, uterus and bladder; all of which has caused her great pain and distress ever since. She has been an inmate of two hospitals in this city on five different occasions in the past five years, being treated each time for ulcers of the leg.

In December, 1913, she had a double plus Wassermann and was being treated in the medical service accordingly over a period of five months, and also in the surgical service for ulcers of the leg. In April, 1914, the Wassermann test showed a single plus.

She was referred to my service for operation June 12, 1914. At this time I discovered a large, gaping perineal opening extending from the symphysis pubis to the coccyx; the uterus and rectum protruding. There was a small bridge of fibrous tissue across this opening about midway between the symphysis and the coccyx, about one-half inch in diameter. I found that I could insert my whole hand into the rectum, pass it under this bridge of tissue and out through the vagina; also that the uterus was so much prolapsed that I could place the fundus up over the symphysis pubis with very little traction. The lower two inches of the anterior rectal wall were completely gone, the rectum uniting with the uterus high up on the cervix. The anterior bladder

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wall presented three small ulcerated openings, all of which were discharging urine, but there was no urethra at all.

I was, as you see, confronted by a rather unusual combination of conditions and decided on a two-stage operation.

The fibrous bridge of tissue was removed and repair of the rectum, sphincter and perineum was done at this time. We first dissected out the external sphincter, which was brought together in the usual way, with chromic catgut sutures. There was still no anterior rectal wall, but one was improvised by dissecting a flap from the posterior part of the cervix until there was enough tissue to complete the rectum, while the uterus was within the pelvis in good position. This was sutured on both sides, restoring the rectum which was, in turn, sutured to the margin of the repaired sphincter. Two of the openings into the bladder were scarified and closed, after which an anterior colporrhaphy and a modified Emmett operation was done on the perineum.

She made a rapid uneventful recovery and was rewarded, much to my gratification, with a good, substantial perineum in spite of the fact that there was a continuous flow of urine. The two openings into the bladder which had been sewed healed up perfectly.

On July 31, 1914, we decided to finish the work by attempting to repair the urethral opening and to restore the uterus to good position by shortening the ligaments within the abdomen. The scar tissue around the remaining opening into the bladder was dissected out and two fine chromic catgut sutures inserted above and below in an attempt to catch the remains of the urethral sphincter. We next dissected a strip of the anterior vaginal wall around and below this opening, dissecting up a flap on either side, but leaving a strip about one-half inch wide for circulation. These flaps were brought together with silk sutures over a hard rubber catheter, which had been introduced into the bladder.

The abdomen was then opened and the ligaments shortened as the case required. The omentum was found to contain multiple cysts of various sizes. Part of this was amputated.

She had a stormy convalescence, contracting a severe case of pneumonia.

The catheter was left in place ten days, after which it, and the stitches, were removed.

Although the perineum does not closely resemble that of a nullipara, she has been relieved of her cystocele, the uterus is in good position, she has now a urethra three-quarter inches in length and enjoys perfect control of feces and urine seven months after date of the first operation.

The leg ulcers which had resisted treatment of various kinds over a period five years have healed. She has gained thirty or forty pounds and has now left the hospital for her home in the country.

Dr. A. B. Hooe said that Dr. Martel was particularly fortunate in the outcome of this case, and the patient was doubly fortunate in falling into the hands of so skillful a surgeon. One would feel entirely comfortable if such a satisfactory result had required even a four or five-stage operation. The presence of the leg ulcers was an interesting feature, and it occurred to Dr. Hooe that their persistence may have been accounted for by the traction of the prolapsed pelvic organs on the iliac veins.

Dr. Bowen was much interested in the case, particularly since Dr. Martel had told him of it and had discussed with him the proposed treatment. So far as the records go, the case was unique for the District of Columbia. A very important factor of Dr. Martel's success was the precaution to have the Wassermann test made and in giving antisyphilitic treatment as a preliminary to the surgical undertaking. We often hear of horrible lacerations as a result of forceps deliveries, but here was an instance of a laceration of the most extreme degree occasioned by ultraconservative obstetric treatment. As to the prevention of such mutilations, every known means should be employed, chief among which may be mentioned the proper use of chloroform and the performance of episiotomy.

Dr. Gannon said that Dr. Martel was to be congratulated upon the surgical skill shown in his management of this case; Dr. Gannon had been familiar with the case throughout and surely no more hopeless situation could be tackled than that faced by Dr. Martel in the case of this woman.

Dr. Jack said that the case illustrated the fact that no matter how hopeless a situation may look, a man may, who works for the work's sake, do much for these poor, hopeless patients. Such an operation and such a result is worth a hundred ordinary perineorrhaphies.

Dr. I. S. Stone said that so far as eulogiums go, nothing remained to be said. As to the preliminary factors of success, this woman had no doubt been given antisyphilitic treatment before; evidently that administered at the Washington Asylum Hospital was better than that previously given, because it was successful. The unusual feature of this operation was the skill and surgical technic which resulted in a restoration of the urethra. This has been a subject of discussion in the gynecologic societies for many years and the surgical problem has always been regarded as most difficult. In spite of every method devised, stitches will cut out and the operation fail. The success in this case no doubt was due to the perfect asepsis maintained, and the use of iodine contributed to the result.

Dr. Martel said in regard to Dr. Hooe's remarks that he agreed that the condition of the pelvic floor had much to do with the disturbed venous flow which in turn was responsible for the failure of the previous treatment of the leg ulcers. There had

been no previous effort to repair the perineum because the condition had been carefully concealed by the patient. Quite vigorous treatment of the syphilis had anteceded her entrance to the hospital. Antisepsis, as suggested by Dr. Stone, had been accomplished by the liberal use of iodine. Dr. Martel wished to call attention to the fact that this case is probably unique in that cervical tissue is now doing duty in the rectum, while vaginal tissue is doing duty as a urethra.

CASE OF PRIMARY CARCINOMA OF LIVER.*

By Harry A. Ong, M. D.,

Washington, D. C.

I desire to report to this Society the following case of primary carcinoma of the liver which occurred in my service at the Washington Asylum Hospital.

Laura Williams, colored; age, 52; admitted, February 26, 1915. Father died of rheumatism; mother died of pneumonia; eight sisters and four brothers dead, causes unknown. Husband died from cerebral hemorrhage. She had two living children in good health; two children died in childhood.

She had measles, chicken-pox, mumps and rheumatism during childhood; otherwise had always enjoyed fairly good health until two years ago, when she was operated on for "tumor." She recovered her health after the operation and felt well until a year ago, when she began to suffer pain in the abdomen. Her abdomen gradually became distended and she steadily lost in weight. When admitted she had very little pain, but was greatly prostrated.

Physical examination, March 2.—An elderly woman, greatly emaciated. Decubitus dorsal. Prostration marked. Skin dry, and over the chest, was scaly. Breasts atrophied. Moderate edema of both lower extremities as well as the lower abdomen. A few scars of healed ulcers on legs. The cervical, axillary, inguinal and epitrochlear glands were palpable. The muscles were flabby; no paralysis. Bones and joints were normal.

The head was normal; there was a yellowish tinge to the sclera; pupils reacted normally. Teeth were in poor condition and the breath was foul; pyorrhoea present. The throat was reddened and the tonsils somewhat enlarged. The thorax was amaciated, with ribs very prominent. There was impairment of resonance with moist râles over both bases. The heart was displaced upwards, the apex beat being in the fourth space ¾ inch inside the nipple line; its action was slow and regular. There was a slight

* Reported to the Medical Society, March 10, 1915.

systolic murmur heard at the apex, not transmitted, and the second pulmonic sound was accentuated.

Abdomen greatly distended. Skin tense and the superficial veins, as well as those over the lower chest, distended. The veins around the umbilicus were dilated. The abdominal walls were very tense and moderate ascites was present. The liver was greatly enlarged, extending down to the pelvis and well over into the left side of the abdomen. Large nodules could be felt through the abdominal wall. Just below the costal margin on the right side and in the subcostal arch the liver seemed to bulge forward. Owing to the tenseness of the abdominal walls nothing further could be made out. A linear scar, resulting from a laparotomy, was seen below the umbilicus.

A diagnosis of malignant disease of the liver was made. Death occurred March 3, a few days after admission to the hospital.

Necropsy at 2 P. M., March 3, 1915, by Dr. R. M. Le Comte: Emaciated negro woman with dark skin; hair clipped. A few pigmented scars scattered over anterior part of wall of thorax. Abdomen greatly distended; palpable mass in upper right quadrant extending into left upper quadrant and below umbilicus into iliac region. Scar of abdominal operation immediately below umbilicus. Clear, yellow fluid flowed from abdomen when cavity was opened. Adhesions of liver to abdominal wall about one inch below and at umbilicus. Surface of liver presented pinkish-white colored nodules. Slight elevation of liver tissue where organ had protruded into space of subcostal angle. Lower margin of ribs fitted into a shallow furrow in the liver. Adhesion of right lung to pleura, more firm posteriorly than anteriorly; very firm adhesions to diaphragmatic pleura. Amount of fluid in pleural cavities normal. Slight adhesions of left lung to pleura posteriorly. Pericardial fluid increased in amount; amber color. Liver extended into right iliac fossa and displaced spleen to left. The growths attached to the liver were adherent to anterior abdominal wall in the right iliac region. Adhesions of lower border of liver to small intestine. Adhesions of omentum to left side of abdominal wall. Pancreas enlarged and firm, normal on section. Left kidney normal in size. Esophagus normal. Stomach small and contracted; pylorus normal; interior of stomach normal. Intestines contracted, except for small part seven to eight inches long above adhesion to liver in right iliac fossa, which was dilated. Transverse colon contracted; sigmoid dilated; ascending colon contracted; appendix normal. No adhesions about uterus, which was normal. Ovaries fibrous. Abdominal aorta small. Retro-peritoneal lymph-nodes enlarged throughout entire attached margin of mesentery. Heart small; tricuspid orifice admitted two fingers; slight thickening of leaflets of tricuspid valve; pulmonary cusps normal; mitral orifice easily admitted one finger; wall of left ventricle reddened

and cut easily; leaflets of mitral valve normal. Aorta normal except for few small patches in aortic sinus. Lower lobe each lung did not crepitate, but dripped blood on section; upper lobe normal. Kidneys cut with difficulty; cortex well differentiated but thin; dripped blood on section; capsule easily stripped. Pancreas slightly longer than normal, superior border covered by enlarged lymph-nodes of the gastro-hepatic omentum; no infiltration. On right side of liver was a large cyst containing amber colored fluid. Oval stone about ¾ inch long in the gallbladder; gallbladder apparently not involved. Liver weighed 22 pounds in fresh state; on section some of the larger nodules were soft and filled with dark blood; smaller nodules were hard and showed cavities on section. Brain and interior of skull normal.

Examination of the masses in the liver showed them to be accumulations of columnar and spheroidal epithelial cells arranged in stratified layers; between contiguous strands of these cells was a poorly developed stroma of vascular tissue. In some parts of the masses, dilated cavities were present, giving the impression of retention cysts in an imperfectly developed duct-system. A delicate capsule of new fibrous tissue was observed at some places on the periphery, in sections stained by van Giesen's method. The liver tissue about the masses showed a narrow margin of compression; apart from this the liver tissue was normal.

From the histological structure of the tumor masses, it seems safe to assume that the new growth was a carcinoma developed from cylindrical epithelial cells, and since the gallbladder, cystic and common bile ducts were not involved, that its origin was in the intrahepatic portion of the hepatic duct. Were we certain that at the abdominal operation, the scar of which was present on the abdomen, no cancerous organ had been removed, the assumption that the growth was primary in the liver substance would be justified. Lymph-nodes from the right border of the gastro-hepatic omentum showed cancerous structure identical with those of the liver tumor.

The scar in the abdominal wall being the only evidence of surgical interference found after a careful post-mortem examination, I think we are justified in presuming that the laparotomy was exploratory. The cancerous lymph glands were so located about the liver as to leave no doubt as to their secondary involvement.

In view, therefore, of the evidence presented, I feel that the case is one of primary carcinoma of the liver. These growths are comparatively rare. In 11,500 autopsies at Guy's Hospital, Hale White found 11 cases of primary carcinoma of the liver, or 0.1 per cent. Eggel estimates that primary carcinoma occurs once in 2,000 autopsies, or 0.5 per cent. The numerical ratio between primary and secondary cancer of the liver has been placed between 1 to 20 and 1 to 40.

Dr. Roy asked how the primary character of the growth was determined; how was it made certain that there might not have been a primary cancerous process in some neighboring lymph node?

Dr. Barton had seen the necropsy in this very interesting case. It had been done by Dr. Le Comte, who made a very careful study of every organ and part of the body; no carcinoma was found elsewhere. There were some lymph nodes involved, but they were in immediate proximity to the liver; the largest of these was adherent to the liver and was quite near a large cancer node in the liver. It seemed quite clearly a case of primary liver cancer.

Dr. E. F. King did not know that primary cancer of the liver was so rare. Many years ago he had presented six large livers before the Society, jointly with Dr. Lamb. One of the specimens was from a policeman, named McNeil, long a familiar figure about town; this liver weighed 29¼ pounds and was the seat of primary cancer.

Dr. Snyder said that it was very interesting to hear the report of this case; it had been his feeling for some time that we have far too few specimens presented at our meetings. This specimen led him to present a case occurring in his own experience: a white woman had tumor like a half orange just below the costal arch, near the midline. It was easily movable and had the appearance of a lipoma of the abdominal wall, which he took it to be. On incising the abdominal wall it was found to be a semi-fluctuating tumor of the liver, which was studded with other nodules farther back. No other abdominal organs were found to be involved.

RESOLUTIONS OF RESPECT IN MEMORY OF DR. RALPH WALSH, FATHER OF DR. F. C. WALSH, A MEMBER OF THE BEXAR COUNTY MEDICAL SOCIETY, TEXAS.

WHEREAS: It was the will of the Great Physician to call Dr. Ralph Walsh to his reward; and,

WHEREAS: We feel that his being called to join the innumerable hosts who have gone before, deprives the entire medical profession of an esteemed and honored member and co-worker and friend, and ends a life of usefulness marked by high professional attainments; and,

WHEREAS: We feel that his transfer to the Higher Life means a distinct loss to the community in which he lived as well as to his son, our brother, and other loved ones,

Therefore, be it resolved: That we extend to his family our deep and heartfelt sympathy, and that a copy of these resolutions be spread upon the minutes of our Society; a copy mailed to the Secretary of the Medical Society in Washington, D. C., of which the deceased was a member, and a copy furnished Dr. F. C. Walsh.

In Memoriam.

DR. LOUIS MYLIUS BABENDREIER.

The committee appointed to take action upon the death of Dr. Babendreier reports as follows:

First of all, Mr. President, it makes the request that it be permitted to throw upon the screen the picture of Dr. Babendreier; secondly, it suggests that if this procedure, new as it affects this organization, meets with the approval of the Society, that the precedent be adopted as a custom, provided it be done, as in this case, without expense to the Society. It makes this simple request because, with the constant augmentation of the Society, it believes that the day is rapidly approaching when the difficulty of identifying a particular member will become even greater than it is now.

There are many here who knew Dr. Babendreier both by face and name; many others who have heard of him, but who never had the opportunity of meeting him; and a few who may have seen him during life, but who need to be reminded of his appearance in order to correctly place him. The picture upon the screen will freshen the memory of all, especially those who have spent much time in his company. And as with this picture of Dr. Babendreier, we feel so it would be with the portraits of others who from the very circumstances of things must sooner or later follow in his footsteps.

Louis Mylius Babendreier, a native of Washington, a pupil of the local public schools and a medical graduate of Georgetown, who died some two weeks ago in the mountains of West Virginia, was a type of the self-reliant American youth who, laboring under the greatest conceivable physical and financial disadvantages, brushes all obstacles aside and through sheer perseverance attains the coveted goal. We can pay no greater tribute to his memory than to quote from a letter of the Sister Superior of St. Francis Hospital in Jersey City, where the Doctor served for a considerable time as an interne in the surgical ward. Of him, the Sister says "his death was indeed a sad shock to myself, to our Doctors and all who were acquainted with him or had met him here, where he was universally esteemed and loved for his many good qualities. Indeed he was a noble character and an honor to his profession, which he loved with enthusiasm. With health and strength he would have made a great surgeon." From other sources, namely, two great surgeons of national reputation, connected with the same institution, we heard similar reports even before Dr. Babendreier's demise. In fact, so highly regarded was Dr. Babendreier at St. Francis that when he had completed his

tenure as intern the staff was loath to let him depart. Therefore, it is superfluous for your committee, whose relations with Dr. Babendreier were most intimate, to reiterate its own convictions. What is most remarkable about Dr. Babendreier is perhaps the fact that while he was a highly cultured man, a brilliant conversationalist, possessing a rich and extensive vocabulary, together with the happy faculty of choosing his words correctly and expressing himself tersely, nevertheless his schooling was elementary, ending with the completion of his first year at High School. Thus it will be seen that he was essentially a self-made man. At a very early age, when most boys are usually care-free, we find him a frail youth serving an apprenticeship under the guidance of his father, a piano maker, whose aim it was to teach his son a trade and make him self-supporting. These years spent at the bench by the side of his parent were perhaps the most profitable in his short career, for it was here under the guidance of a master that Dr. Babendreier developed the wonderful mechanical skill that was his, and which fitted him so eminently for the practice of surgery to which he was wedded. We have heard Professor Billroth say, "Be there ever so much erudition without the requisite manual skill, there can be no surgeon, for however we look upon surgery, surgery is a trade." Dr. Babendreier possessed both surgical knowledge and surgical skill and in addition excellent judgment, qualities which would undoubtedly have placed him ultimately upon a high plane, had he but possessed a more rugged constitution; that was one thing in which he was deficient, for, as many of us already know, Dr. Babendreier was a victim of chronic fibroid phthisis.

Whereas: The Medical Society of the District of Columbia is apprised of the death of Dr. Louis Mylius Babendreier, one of its esteemed members who was beloved and cherished by all, especially the younger members; therefore, be it

Resolved: That the Medical Society expresses its regrets and sorrow at the loss of one of our associates who though still young in years and young in medicine had attained a position of prominence and respect in his profession.

Resolved: That this report be recorded in the minutes of the Society and a copy be transmitted to the widowed mother.*

(Signed) John H. Metzerott,
Geo. M. Kober,
Geo. H. Heitmuller,
Committee.

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*Adopted by the Medical Society March 24, 1915.

DR. LOUIS KOLIPINSKI.

Report of Memorial Committee.

"Greater love than this hath no man, that he died that others might live."

Broken in health from the burdens of an unusually busy life, Louis Kolipinski, physician, surgeon, author and philanthropist, while in the active pursuit of his mission, was summoned to "join the innumerable caravan * * * in the silent halls of death." Thus, after years of service to his fellow creatures, this untiring worker came to his heroic end.

His was the larger life; a life that crams years into months and months into days. The busy practitioner, the scientific investigator, the literary student, the teacher, the writer, the organizer, the welfarer, the husband and father of a well-provided family, these were the attributes of a life summed up in one expression—"my best endeavor."

Louis Kolipinski was born in the capital city November 3, 1859. Twenty years later he graduated from Gonzaga College, receiving the class medal for proficiency in classical studies.

In 1880 he was graduated from the National College of Pharmacy and was given honorable mention for his work in chemistry.

In 1883 he was graduated from the Medical Department of the Georgetown University and was given the gold medal and other student distinctions.

He pursued the study of his chosen profession in the medical centers of the old world and on his return to Washington was made resident physician at Children's Hospital.

In 1884 he became a licentiate of the District Medical Society and was elected to membership October 7, 1885.

In the early nineties he was elected to the faculty of the Medical Department of the National University and was its Professor of Surgery for five years.

Kolipinski's interests, however, centered more especially upon non-surgical therapy, that department of medicine that had been outstripped by the strides in the collateral branches. Therapeutics became his favorite study, in fact, his hobby.

That Kolipinski was an unceasing worker, a thinker and a writer is attested by the thirty or more original contributions to medical literature recorded in the index catalogue of the Surgeon General's Library, all of which were produced at the expense of the midnight oil that burns too rapidly the vitals of the restless enthusiast.

Thus Kolipinski, possibly the busiest of men, with possibly the largest clientele of his day, leaves one undebatable lesson to his professional brothers—dead at the age of fifty-five years from overwork, December 15, 1914.

In his last act to relieve a suffering fellow-man he responded preparedly to his last call.

This was his life, and this, his end. Rich and poor he served alike, and his departure was mourned by hundreds of his followers. The throng that wept this man to his grave were devoted patients whose grief was genuine. As many poor, grief-stricken women and men pressed eagerly forward to gently caress the flowers that mantled his bier, one could not but think of the faith akin to the penitent Magdalen who touched but the hem of His garments; one could not but feel deeply his expression of simple faith, love, devotion, and grateful admiration.

Therefore, be it

*Resolved:** That by the death of Louis Kolipinski the Medical Society of the District of Columbia has lost one of its most earnest workers and scholarly representatives.

That the community has lost a citizen whose professional ability, splendid character and unostentatious life won for him the highest respect and confidence.

That these resolutions be made a part of the records of the Society and a copy transmitted to Mrs. Kolipinski with an expression of sympathy.

(Signed) N. P. Barnes,
D. Olin Leech,
Arthur J. Hall,
Committee.

REPORT OF DR. L. B. T. JOHNSON, DELEGATE TO THE CONFERENCE ON PUBLIC HEALTH AND LEGISLATION, A. M. A.

At the Conference on Public Health and Legislation held in Chicago on Feb. 15th and 16th, the following Proposed Bills were submitted by the Council for discussion:

On Medical Expert Testimony, On Prevention of Infant Blindness, On State Public Health Organization, On State Regulation of those who Treat the Sick.

These proposed bills are hereto appended. It was the purpose of the Conference to present these bills for discussion that the Council might get a representative opinion of their efficacy for probable presentation to a future meeting of The American Medical Association.

In discussing the Model Bill on *State Public Health Organization,* Dr. George B. Young, Commissioner of Health of Chicago, said that he felt that public welfare work, public education and public safety should all be under control of Health Department. Further, he believes that a Health Officer should inspire public

*Adopted by the Medical Society March 31, 1915.

opinion, which in turn should influence the legislative body. There is danger that medical men will urge the enactment of laws which are too far ahead of public opinion and hence difficult of enforcement.

Professor Charles Henderson, of the University of Chicago, felt very strongly the necessity of getting all jails under medical control, that ordinary sanitary and hygienic conditions might be improved. He feels that sick insurance all over the country will be in full force in a few years on account of the increasing expense attached to competent medical advice and treatment.

The general trend of the discussion was that the Health Officer was in danger of being subordinate to the public welfare service, which was felt to be a mistake.

Public health education, it was felt, should start in the schools and all teachers should be required to take a course in health science.

In discussing the *State Regulation of those who treat the sick,* it developed that Kansas has a plan which seems to control the situation, and that is, to have a Board of Education examine every candidate for licensure as to his general premedical education before permitting him to take his medical examination.

Dr. Baldy, of Pennsylvania, recognizes that every pathy has some germ of value, and we should consider these people as specialists, but make them take the regular course in medicine, leaving out surgery and therapeutics, insisting that they learn how to diagnose and then let them practice in any way they desire, the result being that few will persist in quackery.

In the Conference on *Medical Education,* Dr. Bevan, Chairman of the Conference, stated that the classification of medical schools in the past had been temporary. The proposed classification is: *A.* Those which require at least one year of premedical college work and are acceptable; of the 98 colleges, 84 are now in this group. *B.* Those which are doubtful, and which will very soon accept the A standard or close their doors. *C.* Those not acceptable.

It is the expectation that in the near future no classification will be necessary, as all colleges remaining in existence will be in A class.

Dr. Bevan doubts the wisdom of ever compelling medical students to take a four-year premedical college course, as those courses are now given, as it makes the age of graduation and entering upon practice too high. Dr. Bevan also called attention to the fact that it was important that hospitals should be equipped so that an interne year would be of advantage to a graduate and not a waste of time, as was so frequently the case.

Report of the Secretary, Dr. N. P. Colwell, Chicago: As a result of the efforts of this Council, the number of medical colleges had decreased in the United States from over 160 in 1894

to 98 at present, with the probability of several others withdrawing this year. There is a strong tendency toward a two-year entrance requirement to medical schools. At the present time seven States require two years of college work before graduates of medicine may be admitted to examination for license to practice, and this number will probably be increased to ten during present legislatures. There has been a decrease of 10 per cent. in medical registration over last year, bringing total number of students down to about 12,000. Six colleges now require one year in hospital after graduation before diploma is given.

Report of the Committee on the Reorganization of Clinical Teaching, by Dr. Victor C. Vaughan: Dr. Vaughan said that his report was not final, but for the purpose of developing helpful discussion. A properly equipped hospital is essential to a good medical school, and should be under control of faculty where possible. For 100 students there should be a hospital of at least 200 beds divided as follows: 75 beds for medical cases; 75 for surgery, and 50 for obstetrics and gynecology. There should be an out-patient department of 50,000 visits per year. A sociological service should be connected with the hospital. This hospital should include a clinical laboratory; also laboratories for x-ray bacteriology and pathology, and physiological chemistry. The dispensary should also be well equipped and administered. Dr. Vaughan was of the opinion that each clinical department should have an adequate endowment; that the clinical teacher should receive a sufficient salary to render him independent of the necessity of practicing for his livelihood, and this matter was dwelt upon by several speakers.

It was thought that clinical teaching should begin not later than the beginning of the third year, and possibly earlier. Dr. Vaughan believes that instruction in obstetrics and gynecology and possibly ophthalmology, otology, and rhinolaryngology should be completed in third year, advanced work in obstetrics and gynecology being done in fourth year. In planning the construction of a hospital, the bed unit should be used. For acute cases four beds can be cared for by one nurse; more chronic cases, 6 beds; 24 beds is a convenient working unit. There should be a number of clinical clerks from the fourth-year class.

Dr. Vaughan feels the importance of an interne year under the best auspices. Medical colleges should control these appointments. Professors of Medicine and Pathology should unite to give demonstrations in antemortem and postmortem work. Dr. Vaughan feels that at present the full time clinical teacher is not possible for financial reasons.

Dr. Welch, of Baltimore, said that full time clinical teaching was in vogue now at Johns Hopkins, made possible by a very large endowment. He feels that a man cannot be in charge of a

large clinic and maintain a large outside practice, as one or both must suffer.

President Henry S. Pritchett, of the Carnegie Foundation, said that a clinical teacher must consider his teaching first and he must have proper facilities. Advanced requirements are bringing in students who demand a higher clinical standard and half methods of the past no longer meet the situation. He feels that for the good of the public and for the good of physicians themselves, too many half-trained doctors have been graduated.

Dr. Dock, of St. Louis, feels that the standard of hospitals should be raised, as many are of little value to an interne. He feels that there should be a closer connection between the work of the first two years and the second two years, as frequently the student forgets his first two years' work, since he does not have a proper opportunity to use it.

Dr. Baldy emphasized the necessity for colleges reaching the trustees of hospitals to urge upon them the necessity for improving the opportunities of internes.

Dr. Milton T. Rosenau, of Harvard, developed the necessity of giving graduate courses for those desiring to specialize in public health work. Degrees are being given by several universities now for such specialists, the need for whose services is far beyond the supply of available men.

Dr. Colwell made a statement concerning the standardization of hospitals, to the effect that there were 2,424 hospitals in this country with approximately 19,300 beds. All of these hospitals do not have internes and there are hardly enough hospital beds to accommodate the number of students who desire interneships, counting 25 beds to one interne. It is proposed to rate hospitals on 10 different requirements and put them in three classes, A, B and C, as is done with colleges. This rating will be a guide to graduates.

In the joint meeting of the *Federation of State Medical Boards* and the *Association of American Medical Colleges,* President Pritchett said that it was practically impossible to classify colleges, and was disposed to criticize the present medical classification, on the ground that the requirements were not of equal importance. He suggested a classification on the following five standards:

1. The Premedical Education of Students. 2. Character of Instructors. 3. Character of Clinical Work. 4. Character of Laboratories. 5. The amount of money spent.

President Pritchett deprecated the tendency of a medical school to attempt to control the premedical education of its future matriculates.

Dr. Holland, in discussing President Pritchett's paper, stated that in his experience one year of work in chemistry, physics, biology and a modern language given under the direction of a

medical school better prepared the student than did two years of work in most college departments.

Dr. F. C. Waite, in presenting a statement of the minimum expenses of maintaining a suitable college laboratory department, showed that for the 1st and 2d year classes of 50 students each, the expense would be $50,000, of which the students would only pay $15,000.

Dr. Major J. Selig, of St. Louis, made a strong plea for full-time clinical instruction. He developed the fact that medical education had advanced to such a high plane that no clinical instructor could give the proper attention to his teaching when engaged in an outside practice which was at all exacting.

I am very much indebted to Dr. F. A. Hornaday, of George Washington University, for material used in this report, as his short-hand notes were much more complete than I could take.

THE CASE OF DR. T. J. KEMP.

OFFICE OF THE BOARD OF MEDICAL SUPERVISORS OF THE DISTRICT OF COLUMBIA.

WASHINGTON, *January 13, 1915.*

DR. A. L. HUNT, *Secretary,*
The Medical Society of the District of Columbia,
The Burlington, Washington, D. C.

Dear Doctor: Your letter of November 18, 1914, saying "At a recent meeting of the Medical Society of the District of Columbia I was instructed to call the attention of the Board of Medical Supervisors to the advisability of revoking the license to practice medicine of Dr. T. J. Kemp, of this city," was presented to the Board at a meeting held on the seventh instant, and I was directed to inform the Medical Society, through you, that it is not the duty, nor within the province of this Board to investigate rumors of unprofessional conduct on the part of practitioners of medicine in the District of Columbia, and that the Board is not charged with the duty of prosecuting violators of the Medical Practice Act or of Medical Ethics.

I was further directed to inform you that if the Society, by its officers, committees or other representative, will formulate specific charges against Dr. T. J. Kemp, file them with the Board and prosecute said charges either through the office of the Corporation Counsel or by employment of some other attorney at law for said purpose, the Board will give the matter its immediate and most careful attention, and will revoke the license of Dr. T. J. Kemp if the charges presented and the proofs thereof warrant such revocation.

The Society has, evidently, a wrong impression of the duties and powers of the Board in such matters, and the foregoing information is furnished in order that there might be no room for doubt as to the readiness of the Board to perform its full duty both to the profession and to the public. The Board, however, insists that its duties must be performed regularly and in strict accord with the laws which govern its actions.

I am still further directed to inform you that the Board sees no reason to take further action in reference to your letter unless, as suggested above, the Society, which presumably has reliable information upon which its action was based, and specific knowledge warranting such procedure, sees fit to prefer and prosecute charges against Dr. T. J. Kemp which would warrant the revocation of his license to practice medicine in this District.

The Board is not in position to inaugurate charges against Dr. T. J. Kemp, but has authority and is fully prepared to sit in judgment upon any recognizable charges which may be preferred against him by the Medical Society of the District of Columbia.

Respectfully,

GEO. C. OBER, M. D.,
Secretary.

March 3, 1915.

THE COMMISSIONERS OF THE DISTRICT OF COLUMBIA,
WASHINGTON, D. C.

Dear Sirs: Under date of November 18, 1914, the Medical Society of the District of Columbia addressed a letter to the Board of Medical Supervisors of the District of Columbia, calling attention of the Board to the advisability of revoking the license of Dr. T. J. Kemp, of this city, to practice medicine.

The Board replied, under date of January 13, 1915, that it was necessary to formulate specific charges, file them with the Board, and prosecute said charges either through the office of the Corporation Counsel or by the employment of other attorneys for that purpose. A copy of the Board's letter is attached hereto.

In view of the fact that such charges, if filed, are usually prosecuted by the Corporation Counsel, it is requested that the Medical Society may have the aid and advice of the Corporation Counsel in the matter.

The attorneys for the Medical Society, Messrs. McLanahan, Burton and Culbertson, Union Trust Building, are prepared to render assistance possible in this connection.

Very truly yours,

A. L. HUNT,
Corresponding Secretary.

EXECUTIVE OFFICE
COMMISSIONERS OF THE DISTRICT OF COLUMBIA,
WASHINGTON, *March 19, 1915.*

DR. A. L. HUNT,
The Burlington,
Washington, D. C.

DEAR SIR: Your letter of March 3d, enclosing copy of correspondence had by the Medical Society of the District of Columbia with the Board of Medical Supervisors of the District of Columbia, was received on March 4th and sent to the Corporation Counsel for consideration.

The Corporation Counsel states that the law does not make it the duty of the Corporation Counsel or his assistants, unless specifically ordered to do so, to prosecute charges before the Board of Medical Supervisors against physicians for unprofessional or dishonorable conduct. In point of fact, the law makes it the duty of the U. S. District Attorney to prosecute violations of the act creating the Board of Medical Supervisors. The Corporation Counsel adds that in his opinion it would be a very questionable practice for the Corporation Counsel or his assistants to prosecute physicians before the Board of Medical Supervisors upon charges of unprofessional or unethical conduct, or any other case that would justify the revocation of a license.

In view of this opinion the Commissioners suggest that it would be better for you to proceed in accordance with the suggestion contained in the letter from Dr. Ober, dated January 13th, by the employment of an attorney for the purpose. The fact that your letter states that the Medical Society has already retained counsel makes this proceeding simpler and more direct.

Very respectfully,
THE BOARD OF COMMISSIONERS OF THE
DISTRICT OF COLUMBIA,
By
(Signed) LOUIS BROWNLOW,
Acting President.

TUBERCULOSIS.

The following letter was referred by the Medical Society to the Committee on Public Instruction:

"At a recent meeting of the Executive Committee of The National Association for the Study and Prevention of Tuberculosis plans were formulated for a movement among physicians and medical students to secure more interest and coöperation in the Anti-Tuberculosis Campaign.

"As part of the general plan we are anxious to secure the formal coöperation of State and County Medical Societies through-

out the country. We are therefore taking the liberty of directing your attention, as Secretary of your State Medical Society, to this extremely important field of medicine, and of asking your aid in bringing this matter to the attention of your members at the next meeting.

"We have two specific suggestions to offer in this connection. The first is that the State Medical Society, by a special resolution or otherwise, urge upon all of its members the importance of special training in early diagnosis of tuberculosis. To this end we are ready to place your members in touch with the best facilities for accomplishing this training at the lowest possible cost.

"Our second suggestion is that the State Medical Society recommend to each of its county or local societies that at least one of their meetings every year be devoted to the discussion of tuberculosis.

"The services of The National Association for the Study and Prevention of Tuberculosis are at the disposal of your society or any of its branches in the furtherance of either of these suggestions."

Very truly yours,

CHARLES J. HATFIELD,
Executive Secretary.

March 24 the Public Instruction Committee, through Dr. L. B. T. Johnson, Chairman, reported as follows: "In regard to the communication from the National Association for the Study and Prevention of Tuberculosis, your committee recommends that the paragraph stating that the National Association is ready to place the members of the Society in touch with the best facilities for accomplishing a training in the early diagnosis of tuberculosis, at the lowest possible cost, be spread upon the minutes and published in the ANNALS, thus calling this matter to the attention of the members of the Society.

"In regard to the second suggestion, it would appear eminently proper that one evening during each year should be devoted to a symposium on tuberculosis, and it is recommended that such an evening be arranged by the Secretary."

The report and recommendations were adopted by the Society.

PROCEEDINGS OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Wednesday, February 17, 1915.—The President, Dr. Frank Leech, presided; about 100 members present.

After consideration of the report of the Cancer Clinic Committee the report was referred back to the committee for further consideration and report.

Dr. R. S. Lamb read a paper on Subconjunctival injections of salvarsanized serum in the treatment of syphilitic ocular diseases, and presented five patients. Discussed by Drs. Seibert, W. T. Davis, Roy, Hough, Huntington and R. S. Lamb. See page 69.

Dr. Wm. Gerry Morgan read a paper entitled, Syphilitic manifestations in the gastro-enteric tract. Discussed by Drs. Hagner, Camden, Mallory, Christie, Vedder, Bowen and W. G. Morgan.

Wednesday, February 24.—The President, Dr. Leech, presided; about 75 members present.

The Treasurer reported the names of nineteen members delinquent for dues for two years, and announced that he would bring the names of such as had not remitted before the Society for action at the next stated meeting.

The dues of Drs. E. C. C. Winter, F. M. Gunnell and W. W. Wilkinson were remitted until such time as their health would permit their resuming active practice.

Dr. A. B. Hooe, for a Memorial Committee, presented a memorial and resolutions of respect to the memory of Dr. Ralph Walsh. The resolutions were adopted. See page 110.

Dr. Leon A. Martel presented the report of a case of Plastic operation, with result. Discussed by Drs. A. B. Hooe, Bowen, Gannon, Jack, I. S. Stone and Martel. See page 172.

Dr. Chas. A. Ball, of St. Paul, Minn., read a paper on "The Treatment of Nervous Syphilis." Discussed by Drs. Hough, Hagner and Ball.

A unanimous rising vote of thanks was given to Dr. Ball for the courtesy of his appearing before the Society and for his able and instructive paper.

Wednesday, March 3.—The President, Dr. Leech, presided; about 60 members present.

The Treasurer presented his report for February, showing receipts, $98.00; disbursed, $167.36.

An appropriation of $57.88 for expenses of Corresponding Secretary's office was granted.

Dr. G. Wythe Cook, for the Executive Committee, reported that the committee had taken advice from the Society's counsel, Mr. Burton, and that he had prepared a draft of a letter to be sent by the Society to the Commissioners in regard to action in the matter of revoking the license of T. J. Kemp, which draft the committee recommended for the adoption of the Society. See page 186.

The committee recommended also the adoption of resolutions instructing the delegate to the A. M. A. to seek the revision of Sec. 3, Chap. 8, of the By-Laws of the American Medical Association.

"*Whereas*, Section 3, Chapter 8, of the By-Laws of the American Medical Association provides as follows:

"*Effect on Membership of Removal to Another State.*—A member who changes the location at which he practices medicine from the State through whose constituent association he holds membership in the American Medical Association to another State in which there is a constituent association, is eligible to membership in the component society of his new location upon the presentation of a transfer card and an official statement that his dues have been paid in full in the society in which he holds membership. He shall forfeit his membership in the American Medical Association one year after such change of location unless he becomes a member of the constituent association of the State to which he has moved. *Provided, however*, that if the component society into whose territory such member has moved shall refuse him membership, the member shall be privileged to appeal to the Judicial Council of the Association to determine whether or not he be guilty of any act that warrants the enforcement of the provisions of this section. Pending the decision of such appeal, he shall retain his membership in the American Medical Association through his original State association: And *provided, further*, that the term 'the practice of medicine' throughout these by-laws shall be held to mean the offering of service or counsel for the relief of those suffering from abnormal physical or mental conditions: *Provided*, That nothing in this section shall be construed as exempting any member of the American Medical Association from compliance with the requirements of the civil laws of the State or district in which he may have removed."

Be it resolved, That the Medical Society of the District of Columbia is opposed to the foregoing section for the following reasons:

The section is loosely and clumsily worded, and contains provisions of questionable relevancy or practicability. The proviso relating to appeal to the Judicial Council seems meaningless, as it does not appear what "the provisions of this section" are that are to be enforced or how they are to be enforced. According to the apparent intent the operation of the section, if enforceable, could have the effect of compelling local and constituent associations against their will to admit members by transfer from other jurisdictions. This method of admitting members by transfer is not contemplated by the procedure prescribed in the constitution of this Society, or doubtless in the constitutions of many other State associations; hence the virtual effect of this section is autocratically to override and nullify in this respect these constitutions without the consent of the local associations, and even without consulting them. The adherence to the general plan of organization of the American Medical Association required of the constituent associations cannot be con-

strued as granting unlimited control over local affairs. Absolute, complete and unrestricted control over admission to its own membership is a fundamental right vital to the autonomy of any organization. That three outsiders, however excellent, members of the Judicial Council, should have the appellate power to dictate to the hundreds of members of a constituent association as to the admission of new members is totally repugnant to the approved American principle of local self government. Their familiarity with local conditions and local spirit makes the members of a local association far better qualified to act in their own way on applicants for membership than any outside tribunal; their decision should be final, and it is not likely that material injustice will be done. Furthermore, if the right of the American Medical Association to encroach on local prerogatives and override local constitutions in one matter is conceded, there is no limit to the autocratic interference with personal and local independence and privileges to which it or its managers might not attempt to lay claim. For the foregoing reasons the Medical Society of the District of Columbia is not disposed to recognize any authority, jurisdiction or power of interference whatever on the part of the American Medical Association or its Judicial Council with respect to the admission of members or any other purely local matter. Therefore, be it

Resolved, That the Delegate of this Society to the American Medical Association is instructed to offer and promote the adoption of some such substitute as the following for the foregoing Section 3, Chapter 8, of the By-Laws, which should amply meet the requirements of the case:

Removal of Members.—A member of a constituent association removing from the jurisdiction thereof may remain eligible for membership in the American Medical Association for a period of eighteen months following such removal, after which such eligibility shall cease, unless or until it is reëstablished by his becoming a member of the constituent association of the jurisdiction in which he is located.

The report was accepted and the recommendations were adopted by the Society.

The Committee of Censors recommended the following for election to membership. They were all elected:

For active membership:

Claude Carlisle Caylor, University of Virginia, 1910;
Melville Bendheim Fischer, Georgetown University, 1913;
Robert Steele Irvine, Columbia University, 1914;
John Lawson Norris, National University, 1897.

For associate membership:

John Atkinson Ferrell, Assistant Director General, International Sanitary Commission, Rockefeller Foundation;
Louis Anatole LaGarde, Colonel, Medical Corps, U. S. A., retired;

Louis Anatole LaGarde, Jr., Columbia Hospital;
Matthew Reasoner, Captain, Medical Corps, U. S. A.

The following applications for membership were reported and referred to the Committee of Censors:

For active membership:
Eugene Arthur Taylor, University of Virginia, 1908;
Albert Elwood Pagan, George Washington University, 1912;
Leslie Elmo Elliott, American Medical Missionary College, 1904.

For associate membership:
Arthur C. Christie, Captain, Medical Corps, U. S. A.

Dr. Philip S. Roy proposed the following amendment to the by-laws: "Members shall not smoke in the room where the Society is holding its session."

The Committee on Publication was authorized to include in the publication of the proceedings of the memorial meeting in honor of Dr. A. F. A. King, a picture of Dr. King, a list of his writings, and to have prepared reprints to the number deemed proper by the committee.

Dr. W. D. Tewksbury read the paper for the evening, entitled: Artificial pneumothorax in the treatment of pulmonary tuberculosis. Discussed by Drs. Sloan, J. D. Thomas, Ramsburgh, Randolph, Kober and Tewksbury. See page 159.

Wednesday, March 10.—The President, Dr. Leech, presided; about 70 members present.

The Chair announced the death of Dr. Louis Mylius Babendreier, March 7, 1915, and appointed Drs. J. H. Metzerott, G. M. Kober and G. H. Heitmuller a committee on memorial.

Dr. L. B. T. Johnson submitted a detailed report of his attendance as delegate from this Society to the Annual Conference of the American Medical Association on Public Health and Medical Legislation. See page 182.

On motion of Dr. G. Wythe Cook the thanks of the Society were extended to Dr. Johnson for his excellent report.

Resolutions of respect to the memory of Dr. Ralph Walsh adcpted by the Bexar County Medical Society (San Antonio Tex.), were communicated and ordered included in the record. See page 178.

Dr. Harry A. Ong reported a case of Primary carcinoma of the liver and exhibited the specimen. Discussed by Drs. Roy, Barton, E. F. King and Snyder. See page 175.

Dr. W. C. Gwynn read a paper entitled: Prognosis in pulmonary tuberculosis. Discussed by Drs. Tewksbury, Randolph, Paul Johnson, L. B. Thomson and Gwynn.

Dr. A. B. Bennett read a paper entitled: Gram stain smears in oto-rhinology. Discussed by Drs. Macatee, Snyder, Chappell and Bennett.

Wednesday, March 17.—The President, Dr. Leech, presided; about 75 members present.

Dr. Wm. B. Carr presented a specimen of Aneurysm of the aorta and reported the case; he also reported a case of Perforating ulcer of the stomach without antemortem symptoms. Discussed by Drs. Randolph, I. S. Stone, Fremont-Smith and W. B. Carr.

Dr. W. S. Bowen's case report of Breech presentation was read by Dr. Martel, Dr. Bowen being unable to attend the meeting. Discussed by Drs. Fry, I. S. Stone, A. B. Hooe, A. L. Stavely, Chappell, Frankland and Martel. See page 131.

Dr. C. A. Pfender read a paper entitled: X-ray treatment of myositis ossificans. Discussed by Drs. Lemon, Glushak, Paul Johnson, Macatee and Pfender. See page 146.

Wednesday, March 24.—The President, Dr. Leech, presided; about 70 members present.

Dr. Metzerott, for a Memorial Committee, presented resolutions of respect to the memory of Dr. Louis Mylius Babendreier, which were adopted. See page 179.

Dr. L. B. T. Johnson, for the Committee on Public Instruction, reported recommendations for coöperation by the Society in the purposes of the National Association for Study and Prevention of Tuberculosis. The report and recommendations were adopted. See page 188.

The committee recommended the publication of a statement with regard to the present status of Twilight sleep. This report was referred back to the committee for revision and subsequent review by the Society.

Dr. E. A. Balloch presented a case and specimen of Papillomatous cyst of the nipple. Discussed by Drs. Simpson and Balloch. See page 158.

Dr. Stavely reported a case of Peridiverticulitis. Discussed by Drs. Macatee and Jack. See page 167.

Dr. John Constas read a paper entitled: The results of salvarsan and neosalvarsan in primary syphilis. Discussed by Drs. Simpson, Vedder, Kemble, Hough, Reasoner, E. F. King, R. A. Hooe and Constas.

Wednesday, March 31.—The President, Dr. Leech, presided; about 95 members present.

Dr. Barnes, for an Auditing Committee, reported that the accounts of the Committee on Reception of Virginia State Medical Society had been examined and found correct; a small balance had been turned over to the Emergency Hospital, as instructed by the Society. The committee was given the thanks of the Society, and discharged.

Letters from Mrs. Ralph Walsh expressing her appreciation of memorial resolutions in honor of Dr. Walsh were read. The

Secretary was instructed to send a copy of the resolutions to the Bexar (Texas) County Medical Society.

Dr. N. P. Barnes, for a Memorial Committee, presented a report with resolutions of respect to the memory of Dr. Louis Kolipinski. The report and resolutions were adopted. See page 181.

A letter from the District Commissioners relative to the proper procedure in seeking the revocation of the license of a physician was referred to the Executive Committee. See page 186.

An appropriation of $171.64 for publication of the ANNALS and for reprints of King memorial proceedings was granted.

Dr. J. F. Mitchell reported a case of Splenectomy for pernicious anemia, and exhibited the spleen. Discussed by Drs. Elsner, of Syracuse, N. Y., and Dr. Adami, of Montreal.

Dr. Chas. S. White reported two cases of Ulcer of the stomach, and exhibited specimens. Discussed by Dr. Verbrycke. See page 156.

Dr. Reichelderfer reported a case of Unusual foreign body in appendix. Discussed by Drs. Mitchell, Bowen, Balloch, A. B. Hooe, Jack, Boveé and Reichelderfer. See page 154.

Dr. E. M. Parker reported two cases of Transduodenal choledochotomy. Discussed by Drs. Reichelderfer and Parker.

Dr. Wm. C. Borden read a paper on Pericolic adhesions, and reported cases. Discussed by Drs. Hagner, Mallory, Verbrycke, Williams, Boveé, H. H. Kerr and Borden.

WASHINGTON MEDICAL ANNALS.

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Editorial.

HISTORY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.—Price $1.00, with 25 cents added if delivered in this city or sent by mail. Address Dr. C. W. Franzoni, 605 I Street, N. W. The books are in the custody of Dr. D. S. Lamb, at the Army Medical Museum.

THE WASHINGTON MEDICAL ANNALS, the official organ of the Medical Society of the District of Columbia, issued the first of January, March, May, July, September and November, will publish gratuitously such information of a medical, surgical and sanitary character, changes in personnel, &c., of hospitals, dispensaries, medical schools, medical societies and other medical agencies, as would be useful and interesting to the members of the Society. Address the Chairman of the Committee on Publication, Dr. D. S. Lamb, 2114 Eighteenth St., N. W.

THE WASHINGTON MEDICAL ANNALS.—Back numbers.—Members of the Society who have back numbers of the ANNALS, and do not intend to preserve them, are requested to send them to the Chairman of the Publication Committee. Requests for such numbers are frequently received. Address Dr. D. S. Lamb, Army Medical Museum.

THE OTHER MEDICAL SOCIETIES OF THE DISTRICT OF COLUMBIA.

ALUMNI MEDICAL SOCIETY OF GEORGETOWN UNIVERSITY.—Active membership of 110; meets on the third Saturday of the month at the Medical School. Officers: W. M. Barton, President; Chas. I. Griffith, Recording Secretary; J. M. Moser, Corresponding Secretary; Ralph O'Connor, Treasurer.

CLINICAL SOCIETY.—Officers: F. L. Biscoe, President; W. J. Mallory, Vice President; E. P. Copeland, Secretary-Treasurer; Censors: L. A. Johnson and J. D. Thomas.

1915.	*Meeting Place.*	*Essayist.*	*Discussion by.*
May 10.	Banquet.		
October 12	Dr. J. D. Thomas	Dr. C. S. White	Dr. Reichelderfer.
November 9	Dr. E. P. Copeland	Dr. W. A. Wells	Dr. Richardson.

CLINICO-PATHOLOGICAL SOCIETY.—Active membership limited to 25. Inactive membership: those who have withdrawn from active membership after 15 years. A limited honorary membership of eminent medical men. Meets on the first and third Tuesdays of the month from October to May, inclusive. Officers: President, J. D. Thomas; Vice Presidents, Loren Johnson and H. P. Parker; Secretary and Treasurer, B. M. Randolph.

FREEDMEN'S HOSPITAL MEDICAL SOCIETY.—Meets on the second Wednesday of each month from October to May, inclusive. Composed of physicians connected with the Staff of the Hospital and the Medical Faculty of Howard Medical School. E. A. Balloch, President; S. L. Carson, Vice President; C. A. Allen, Secretary-Treasurer; Committee on Program, E. A. Balloch, S. L. Carson and H. H. Hazen.

GALEN SOCIETY of the District of Columbia.—Wm. H. Littlepage, President; Harry A. Ong, Secretary.

1915.	*Place.*	*Essayist.*
May 17	Dr. Spire 1609 North Capitol Street.	Clinical.
October 18	Dr. Pfender 304 Rhode Island Avenue, N. W.	Business Meeting. President's Address.
November 15	Dr. Henning The Rochambeau.	Dr. Pfender.
December 20	Dr. Titus 1730 M Street, N. W.	Clinical.

GEORGETOWN CLINICAL SOCIETY; twenty-five active members, limited to graduates of the Medical Department of Georgetown University. Meets at the University Club on the third Tuesday in the month. John Foote, President; J. Russell Verbrycke, Jr., Treasurer.

HIPPOCRATES SOCIETY, membership limited to 25, with voluntary retired members after 10 years, meets on the second Thursday of the month from October to May. Officers for the year: J. R. Verbrycke, Jr., President; C. A. Simpson, Secretary.

1915.	*Place.*	*Essayist.*
May 12	Dr. Moore	Dr. White.

MEDICAL HISTORY CLUB of Washington, D. C.—Officers: President, Philip Roy; Vice-President, F. H. Garrison; Secretary, John Foote; Executive Committee, I. S. Stone, H. W. Lawson, Wm. A. White and the Officers. Members: Truman Abbe, Frank Baker, W. C. Borden, Joseph H. Bryan, G. Wythe Cook, John Foote, F. H. Garrison, Howard Hume, H. W. Lawson, W. J. Mallory, G. Brown Miller, J. D. Morgan, John B. Nichols, P. S. Roy, I. S. Stone, John D. Thomas, Wm. A. White, W. W. Wilkinson, Mathew Kollig.

MEDICAL AND SURGICAL SOCIETY of the District of Columbia.—President, John Dunlop; Vice President, H. H. Hazen; Secretary and Treasurer, L. Eliot; Asst. Secretary, L. C. Ecker; Executive Council, O. A. M. McKimmie, E. L. Morgan, L. Eliot, L. H. Reichelderfer and Ecker.

SOCIETY OF MEDICAL JURISPRUDENCE, Washington, D. C. —President, Dr. Wm. A. White; Vice President, R. Ross Perry; Secretary-Treasurer, Dr. D. P. Hickling. Meets on the second Monday of each month from October to June at University Club. Has from forty to fifty members.

SOCIETY OF OPHTHALMOLOGISTS AND OTOLOGISTS, Washington, D. C., meets the third Friday of each month from October until May, inclusive.

Officers: President, L. S. Greene; Vice President, A. B. Bennett, Jr.; Secy.-Treasurer, A. H. Kimball, The Farragut.

Active members: Drs. A. B. Bennett, Jr., J. W. Burke, V. Dabney, W. T. Davis, L. S. Greene, C. Henning, E. B. Jones, A. H. Kimball, R. S. Lamb, F. B. Loring, O. A. M. McKimmie, W. B. Mason, M. E. Miller, Mead Moore, S. B. Muncaster, W. S. Newell, J. J. Richardson, E. G. Seibert, R. R. Walker, W. A. Wells.

Inactive members: Drs. J. H. Bryan, W. K. Butler, H. S. Dye, Wm. H. Fox, W. P. Malone, H. A. Polkinhorn, C. W. Richardson, D. K. Shute, W. H. Wilmer.

Society of Social Hygiene, Washington, D. C.—President, Surgeon General Stokes, U. S. Navy; Secretary, Lt. Col. J. R. Kean, U. S. Army, Surgeon General's Office. The Society has four committees, namely: Education, Venereal Diseases, Protection of Women and Children, and Psychopathology. Yearly dues, $1.00. Persons desiring to become members should address Col. Kean and state to which committee they wish to be assigned.

Therapeutic Society of the District of Columbia.—Meets at the G. W. School of Pharmacy, 808 I Street, N. W., on the first Saturday in each month. G. W. Latimer, President; A. P. Tibbets, Secretary.

Walter Reed Medical Society meets on the fourth Thursday of every other month, from September to May inclusive. Composed of physicians located in the eastern part of Washington. Officers: J. S. Arnold, President; H. R. Schreiber, Vice President; M. H. Prosperi, Secretary; N. E. Webb, Treasurer.

Washington Medical and Surgical Society.—President, Neil D. Graham; Vice President, R. R. Walker; Secretary, Walter Van Sweringen; Treasurer, Frank E. Gibson; Curator and Librarian, E. H. Egbert. Executive Committee: L. H. Taylor, Chairman; G. S. Clark, G. S. Barnhart. Program and Auditing Committee: Wm. A. Jack, Jr., Chairman; J. R. Nevitt, Walter Van Sweringen. Membership Committee: Frank E. Gibson, Chairman, Wm. P. Reeves, Caryl Burbank.

Program—1915.

Essayist.	*Date and Host.*	*To open Discussion.*
To be selected	May—Annual Banquet.	
President's Address	October 25, Dr. Emmons	Dr. Braden.
Dr. Taylor	November 22, Dr. Frankland	Dr. Burbank.
Dr. Van Sweringen	December 20, Dr. Gibson	Dr. Clark.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY. —President, J. F. Moran; Vice Presidents, G. B. Miller, Prentiss Willson; Secretary, Truman Abbe; Treasurer, D. W. Prentiss. Retired Members—Drs. G. N. Acker, S. S. Adams, E. A. Balloch, J. W. Bovée, W. S. Bowen, W. P. Carr, G. Wythe Cook, M. F. Cuthbert, Henry D. Fry, H. L. E. Johnson, J. T. Johnson, D. G. Lewis, A. R. Shands, E. E. Morse, Elmer Sothoron, J. Ford Thompson, John Van Rensselaer.

Program—1915.

Date.	*Essayist.*	*Reporters.*	*Host.*
May 14	Dr. G. B. Miller	Dr. H. W. Lawson Dr. Howard Hume.	Dr. Sprigg.
October 8	Dr. J. F. Moran	President's Address Election of Officers.	Dr. Lowe.
November 12	Dr. S. L. Owens	Dr. Karl Corley Dr. R. Y. Sullivan.	Dr. Prentiss.
December 10	Dr. John Foote	Dr. L. A. Martel Dr. C. S. White.	Dr. Riggles.

WASHINGTON SOCIETY OF NERVOUS AND MENTAL DISEASES. —President, Wm. H. Hough; Vice President, Bernard Glueck; Secretary, J. J. Madigan. The Society has a limited membership of thirty, but welcomes Physicans and Surgeons interested in Neurology and Psychiatry. Meets monthly on the third Thursday at the Cosmos Club or a member's residence.

WOMEN'S MEDICAL SOCIETY of the District of Columbia. —President, Sophie Nordhoff-Jung; Vice President, Ada R. Thomas; Secretary and Treasurer, A. Francis Foye; Corresponding Secretary, Margaret R. Stewart.

THE SECRETARIES of the other Medical Societies of this District are reminded that the ANNALS will publish the schedules of their meetings.

THE TRAVEL STUDY TOUR of the Travel Study Club of American Physicians to the A. M. A. meeting, San Francisco Exposition, Honolulu, Japan, the Philippines, China, and around the world, 1915. Those interested address the business manager of the McCann's Tours, 1328 Broadway and 34th Street, N. Y. City.

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS.—The following amendments have been made since the publication in Volume XII, March, 1913.

Constitution.—Article V, Section 4; adopted Nov. 4, 1914: before the words "Due notice" on page 142, insert "No application for membership that is rejected or withdrawn shall be renewed until after two years from the time of its rejection or withdrawal."

Section 10, same article; adopted Jan. 7, 1914: for "two years" substitute "one year."

Article VI, Section 5, adopted Jan. 6, 1915: in the last line, for "two" substitute "three."

Article VIII, Section 2, page 148, 4th line from top: for the word "disorders" substitute the word "diseases."

By-Laws.—Article VIII, Section 9, page 153: adopted Jan. 7, 1914: No member of the Staff of any hospital receiving patients in private rooms shall attend such private patient sent to the hospital by a member of the Society, not a member of the Staff, unless specifically requested to do so by the attending physician.

Please note that the figures in Sections 7 and 8 of this article, instead of being 7 and 8 should be 5 and 6.

Dr. T. A. Williams, 1705 N St., N. W., a committee on collecting instruments for Belgian Physicians, will be glad to receive any instruments that members of the Society can spare, however old such instruments may be. Kindly send to Dr. Williams or notify him that you can contribute them.

Belgian Relief.—Miss Winifred Holt, Secretary of the New York Association for the Blind, has returned from Europe, where she went in the interest of the blind Belgian refugees. She says that it is estimated that one person in every 1,200 in Belgium was either partially or totally blind; about 8,000 in all. When Belgium became the hotbed of war there were thirteen institutions for the blind, deaf and dumb. These were all wrecked, and their sorry inhabitants poured forth in a mad rush of surging masses of blind men and women and children, seeking such guidance as they could get, groping for places of safety. They must now be scattered among the helpless, starving, unfortunate refugees standing in the breadline that stretches all over Belgium.

The President of the National Relief Commission of Brussels asserted, March 25, that before the next harvest 2,500,000 Belgians will be in the breadline. Foodstuffs must continue to be provided in the fairly regular way in which they have been supplied heretofore. Belgium has been saved from the intermittent periods of starvation by the personal sacrifices of the Directors of the American Commission who have at these times pledged their personal credit for as much as $10,000,000.

The medical profession of America must see to it that our Belgian colleagues and their families are saved from such intermittent periods of starvation by keeping the stream of food and supply boxes pouring in to them in a steady flow.

In an address delivered recently by Mr. Lindon W. Bates, Vice Chairman of the Commission for Relief in Belgium, he said:

"The Commission was granted by the German Government not only the sole right to transport food into Belgium but given the active sympathy and aid of the German military authorities. Despite reports to the contrary, not one pound of food sent in has been appropriated. The treasury of the Commission draws from

the generous heart of the world. Into this treasury has been put also all that the enveloped Belgian race could gather of the remnants of their shattered fortunes. It registers their struggle for survival. It represents their very all—the all that the better-to-do can give to help themselves and unreservedly to help their fellow beings in the ranks already destitute and starving. This is our main purchasing fund—the greatest and the sacredest of all the donations."

There is a committee of Belgians formed to consider the condition of the doctors and pharmacists. It is a representative body and has organized machinery for ascertaining where the need is greatest among whom it would help and providing systematic relief. Forms have been issued to all the doctors and pharmacists in Belgium on which they are asked to state frankly their positions and that of their families, the loss they have sustained and the estimated amount of money to enable them to tide over their existing terrible circumstances. On these points the committee has acted in consultation with the local medical societies throughout Belgium and with the government inspectors of pharmacy. Small amounts of money have been distributed in this way and the better circumstanced doctors and pharmacists of the larger cities of Belgium have contributed to this fund. Originally this committee had a subsidy from the national relief fund, but this is now exhausted. The British committee has investigated this work and is advising now that help in money should be sent.

Belgian Scholarship Committee, Washington, D. C.—In consequence of the devastation of Belgian museums, libraries and universities, numerous worthy students, research workers and professors, many of them crippled for life, are interrupted in their important work. To the lovers of equity and to those who cherish education and admire Belgian integrity and heroism an opportunity is hereby given to assist in bringing to America worthy intellectual men and women for a temporary free enjoyment of the privileges of American institutions.

This committee has already received assurances from the George Washington University for the instruction of ten students in any of the departments of the University. It is highly probable that the committee will receive from other American institutions similar assurances.

It is proposed to raise a fund at once to defray the traveling expenses to and from Belgium and the cost of residence in Washington for a period of one year of the students or research workers which the George Washington University has already generously provided for. In the case of professors it is hoped that the subscriptions will be sufficiently liberal to provide for honorariums as well, thereby giving all the students in Washington the benefits of lectures by Belgian scholars.

It is estimated that from $20,000 to $25,000 will be needed in

the work at once, and in the event of a surplus being accumulated, it is proposed to apply this to the recuperation of educational work in Belgium. This committee is a subcommittee of the Central Committee for the Belgian Relief Fund for Women and Children and other noncombatants, and it is organized with the approval of his Excellency, the Minister from Belgium to the United States.

Please draw checks payable to Belgian Scholarship Committee, John Joy Edson, Treasurer, Washington Loan and Trust Building, Washington, D. C. Checks for any amount, large or small, are earnestly asked for.

PRIZE.—The American Social Hygiene Association has been offered a prize of $1,000 by the Metropolitan Life Insurance Company, to be awarded to the author of the best original pamphlet on social hygiene for adolescents between the ages of twelve and sixteen years, approved by a committee of judges to be selected by the Association. Competition for the prize is open to all. The contest will close July 31, 1915, at midnight. Manuscripts should not exceed 3,500 words; must be in English; must not have been previously published; must be typewritten on one side only of plain white paper 8 inches by 10½ inches; must be paragraphed and punctuated for submission as "copy" to printer; must bear some identifying mark or pen-name, but not the name of the author. The author's name and address and the identifying mark or pen-name should be in a sealed envelope, accompanying the manuscript; the face of the envelope should bear the mark or pen-name only. More than one manuscript may be submitted by the same author. The winning manuscript, in consideration of the award of $1,000, becomes the property of the donor of the prize, all rights therein being surrendered by the author. The right to purchase any manuscript submitted, at the rate of 5 cents a word, is reserved by the Metropolitan Life Insurance Company and by the American Social Hygienic Association. Any manuscript not winning the prize or purchased will be returned to the author if return postage is provided.

Address manuscripts and requests for further information to the American Social Hygiene Association, 105 West 40th Street, New York City.

THE SEVENTH PAN-AMERICAN CONGRESS will meet in San Francisco June 17–21, inclusive. It assembles pursuant to invitation of the President of the United States issued in accordance with an act of Congress approved March 3, 1915.

The Congress will meet in seven sections, viz: (1) Medicine; (2) Surgery; (3) Obstetrics and Gynecology; (4) Anatomy, Physiology, Pathology and Bacteriology; (5) Tropical Medicine and General Sanitation; (6) Laryngology, Rhinology and Otology; (7) Medical Literature.

All members of the organized medical profession of the constituent countries are eligible and are invited to become members. The membership fee is $5.00 and entitles the holder to a complete set of the transactions. Advance registrations are solicited and should be sent with membership fee to the Treasurer, Dr. Henry P. Newman, Timken Building, San Diego, California.

The general railroad rate of one fare for the round trip, good for three months, made on account of the Panama-Pacific Exposition at San Francisco and the California Exposition at San Diego is available for the Pan-American Medical Congress.

The Palace Hotel will be headquarters.

CHARLES A. L. REED, President, Union Central Building, Cincinnati; HARRY M. SHERMAN, Chairman Committee of Arrangements, 350 Post St., San Francisco; RAMON GUITERAS, Secretary-General, 80 Madison Ave., New York City; PHILIP MILLS JONES, Special Committee on Hotels, 135 Stockton St., San Francisco.

DR. FRANCIS DUVAL KOONCE died of pneumonia in this city March 24, 1915, age 46. Born January 19, 1868, at Richland, N. C. Graduated M. D., Southern Medical College, Atlanta, Ga., 1893. Practiced in Richland in 1897–8; in Raleigh in 1898. Served as assistant physician, North Carolina Insane Asylum, Raleigh, 1898. Was a member of the Southern Medical Society, Atlanta. Practiced in Washington from about 1900. Elected member of Medical Association District of Columbia Oct. 6, 1903; dropped from membership Dec. 17, 1907; never joined the Medical Society.

DR. ROBERT FARNHAM died in a sleeping car at Altoona, Pa., February 23, 1915. Dr. Farnham was born in this city in 1843; graduated M. D., University Pennsylvania, 1867; was elected a member of the Medical Association District Columbia, July 8, 1871; was dropped from membership June 22, 1909; never joined the Medical Society.

THE CANCER PROBLEM.—The American Society for the Control of Cancer has sent to a large number of departments of health and medical journals a copy of the Quarterly Bulletin of the New Hampshire State Board of Health for January, 1915, containing a review of cancer in that State for the last twenty years and advice to the public regarding the need of early recognition and operation. Also an abstract of an article by Dr. J. A. Watson, Secretary of the State Board of Health, on the same subject.

DELINQUENT REGISTRATION BOOK.—The Secretary of the Emanuel County Medical Association, Georgia, keeps a book in his office, containing the names of delinquent patients and of the physicians who report these names. The book is open to inspection of the physicians, members of the Society. A delinquent is

so considered when his indebtedness is of one year's standing and no satisfactory arrangement has been made to pay. There are a number of rules governing the conduct of this effort to compel patients to pay doctor bills.

United States Navy.—Examination for appointment in the Medical Corps will take place about July 6 1915. Application should be made to Surgeon-General U. S. Navy, Navy Department, Washington, D. C., not later than June 26.

United States Public Health Service.—Examination of candidates for appointment as Assistant Surgeon in this service June 21, 1915, at 10 A. M., at the Bureau, No. 3, B Street, S. E. For further information address the Surgeon General, P. H. S., Washington, D. C.

American Proctologic Society.—17th Annual Meeting at San Francisco, Cal., June 21 and 22. 1915. Headquarters at St. Francis Hotel; place of meeting the Civic Auditorium. Dr. T. C. Martin is an Active Fellow, and Dr. Rolla Camden an Associate Fellow.

REVIEWS.

John Shaw Billings; A memoir. By Fielding H. Garrison, M. D. Published by Putnam's Sons, New York and London, 1915. Price, $2.50.

This memoir is written in the usual excellent style of Dr. Garrison; the story of a remarkable man; an unusual man, as is well known to those who were more or less intimate with him. A most interesting book to those who knew him, and not without interest to those who appreciate a forceful character with wonderful working power. Dr. Billings was too well known in this city to need further encomium.—D. S. Lamb.

RECENT PUBLICATIONS OF PHYSICIANS IN THE DISTRICT OF COLUMBIA.

J. F. Anderson; Laboratory diagnosis of bubonic plague; *Amer. Jour. Pub. Hlth.*, February.

W. M. Barton; Partial myxoedema with report of case; *Jour. A. M. A.*, March 20, page 986.

J. W. Bovée; Case of chorio-epithelioma malignum complicating two months pregnancy and degenerated uterine fibroma; *Surg. Gynec. and Obst.*, April.

S. L. Carson; Oration in surgery; Acute indigestion; *Jour. Nat. Med. Assn.*, January–March, page 1.

H. R. Carter, P. H. S.; Impounded water; Public Hlth. Re-

ports, Dec. 25, 1914; abstracted in *South. Med. Jour.*, April, page 291.

R. M. Chapin and W. C. Powick; Improved method for estimation of inorganic phosphoric acid in certain tissues and food products; *Jour. Biol. Chem.*, February; abstracted in *Jour. A. M. A.*, March 13, page 941.

K. C. Corley; Sacro-iliac strain; *Amer. Jour. Obstet.*, April.

H. K. Craig; Christian Science cures; *N. Y. Med. Jour.*, March 13.

C. R. Dufour; A plea for coöperation of physicians to prevent deafness; *Va. Med. Semi-mo.*, April 23, page 34.

H. E. Dunne; Piles, with especial reference to the method of interstitial invasion as applied to the internal variety; *ibid.*, page 38.

A. M. Fauntleroy, U. S. N.; Shock, anoci association and anesthesia; U. S. Naval Med. Bull., January; abstracted in *South Med. Jour.*, April, page 308.

A. D. Foster, P. H. S.; Interstate migration of tuberculous persons; Reprint 265 from Pub. Hlth. Reports, March 12.

Carroll Fox, P. H. S.; Public health administration in the state of Washington; Reprint 255 from Pub. Hlth. Reports, February 5.

F. H. Garrison; John Shaw Billings, a memoir; Putnam's Sons, N. Y. and London, 1915, Price $2.50. Also Sir Michael Foster and the Cambridge school of physiologists; *Maryland Med. Jour.*, May, page 105.

C. T. Grayson, U. S. A.; The old-time doctor; *Kentucky Med. Jour.*, April 1, page 178.

F. R. Hagner; Acute hematogenous infection of the kidney; *Va. Med. Semi-mo.*, April 23, page 30.

H. H. Hazen; Prickle cell and basal cell skin cancers; *Jour. A. M. A.*, March 20, page 958.

W. H. Huntington; Report of case of latent mastoiditis with sinus thrombosis; *Va. Med. Semi-mo.*, Feb. 12, page 533; abstracted in *South. Med. Jour.*, April, page 326.

J. T. Johnson; Solid fibroid tumor of ovary; *N. Y. Med. Jour.*, March 20.

Glenn I. Jones, U. S. A.; The treatment of intestinal amebiasis; *Jour. A. M. A.*, March 20, page 982.

D. S. Karstoroom; Significance of acids and alkalies in organic world; *Med. Record, N. Y.*, March 27.

E. F. King; Persistent glycosuria, a symptom of functional liver failure from focal infection; *Wash. Med. Annals;* January, page 30; abstracted in *South. Med. Jour.*, April, page 277.

J. J. Kinyoun; Modification of Ponder's stain for diphtheria; *Amer. Jour. Pub. Hlth.*, March.

G. M. Kober; Nostrum evil; *Jour. Outdoor Life*, March.

R. S. Lamb; Case of mixed irregular astigmatism following injury; *Ophth. Record*, March.

C. H. Lavinder, Edward Francis, R. M. Grimm, and W. F. Lorenz; Attempts to transmit pellagra to monkeys; *Jour. A. M. A.,* Sept. 26, 1914, page 1093; abstracted in *Pathologia,* Genoa, Italy, February 15, page 93.

H. P. Letton; Rat proofing the public docks of New Orleans; Reprint 259, Pub. Hlth. Reports, Feb. 19.

John E. Lind; Combined psychoses; *Jour. Nerv. and Ment. Dis.,* April.

M. W. Lyons, Jr.; Ancylostoma not ankylostoma; *Jour. A. M. A.,* May 1, page 1519. Also, Nichrome as a substitute for platinum wire in bacteriologic inoculations; *Jour. A. M. A.,* March 27, page 1069.

T. C. Lyster, U. S. A.; Sanitation in Vera Cruz; *Va. Med. Semi-mo.,* March 26, page 599.

W. J. Lyster, U. S. A.; Sterilization of drinking water by calcium hydrochlorite, in the field; *Military Surgeon,* March.

Arthur McDonald; War and criminal anthropology; *Pacific Med. Jour.,* April, page 251.

W. J. Manning; Micrographic study of the tubercle bacillus; *N. Y. Med. Times,* March.

W. G. Morgan; Syphilis of stomach, report of cases; *Amer. Jour. Med. Sci.,* March.

J. A. D. Pfeiffer; Case of chronic progressive chorea; *Amer. Jour. Insanity,* January; abstracted in *Jour. A. M. A.,* March 13, page 937. Also, Neuropathologic findings in case of pernicious anemia with psychic implication; *Jour. Nerv. and Mental Dis.,* February; abstracts in *Jour. A. M. A.,* March 20, page 1032.

E. C. Prentiss; Infection with cercomona hominis; *New Orleans Med. Jour.,* Dec., 1914, page 92; abstracted in *South Med. Jour.,* April, page 291. Also, Observations upon certain protozoal infections of the digestive system; Trans. First Annual Session Southwestern Medical and Surgical Assn., page 29.

T. W. Richards, U. S. N.; Battleship ventilation; U. S. Naval Med. Bull., April, page 345.

W. Salant and E. K. Nelson; *Amer. Jour. Physiology,* March.

A. R. Shands; The operative treatment of fracture; *Va. Med. Semi-mo.,* Jan. 22, page 501; abstracted in *South Med. Jour.,* April, page 307, and *Amer. Jour. Surgery,* May, page 195.

G. H. Shaw; Federal meat inspection service and sanitation of packing houses under its supervision; *Amer. Jour. Pub. Hlth.,* March.

E. R. Stitt, U. S. N.; Leukopenia of a marked degree in a fatal case of pneumonia; U. S. Naval Med. Bull., April, page 275.

E. B. Vedder, U. S. A., and W. H. Hough; Prevalence of syphilis among the inmates of the Govt. Hosp. Insane; *Jour. A. M. A.,* March 20, page 972.

F. C. Walsh; Hematuria and its possible significance; *New Or-*

leans Med. and Surg. Jour., January, page 631; abstracted in *South. Med. Jour.,* April, page 276.

L. Wender; Applicability of Binet-Simon intelligence tests in psychoses; *N. Y. Med. Jour.,* March 6.

M. I. Wilbert; The purity and strength of household remedies; Reprint 254 from Pub. Hlth. Reports, Jan. 29. Also, Poison and habit-forming drugs; Reprint 240 from Pub. Hlth. Reports, Nov., 1914; supplement to Pub. Hlth. Bull., No. 56.

T. A. Williams; Faith cures and how they are contrasted with the principles of scientific mental healing; with case reports; *Pacific Med. Jour.,* March, page 157. Also, Remarks on intrathecal injections as a factor in the improvement of tabetics after salvarsan; Same journal, April, page 251. Also, Treatment of psychoneurotic patients; *Cleveland Med. Jour.,* January. Also, Circumscribed serous meningitis; *N. Y. Med. Jour.,* April 24.

PERSONAL NOTES.

P. M. Ashbur, Major, M. C., U. S. A., ordered to duty to Walter Reed Hospital.

B. H. Dorsey, U. S. Navy, ordered to duty in Bureau of Medicine and Surgery, Navy Dept.

A. M. Fauntleroy, U. S. Navy, from Naval Hospital, to Assistant to Naval Attaché, Paris, France.

Howard Fisher sailed on the Lusitania for England, to assist in forming a hospital unit of the British Red Cross. The vessel was torpedoed by a submarine and sank, but Dr. Fisher was saved.

J. F. Hall, Major, M. C., U. S. A., ordered to Walter Reed Hospital; takes command of the Field Hospital unit.

P. S. Halloran, Major, M. C., U. S. A., transferred from Walter Reed Hospital to Fort Sill, Oklahoma.

E. C. Jones, Captain, M. C., U. S. A., ordered for duty to Walter Reed Hospital to take command of the Ambulance company.

W. G. Smith, Captain, M. C., U. S. A., ordered to duty at Walter Reed Hospital.

T. A. Williams addressed the Academy of Medicine, Jacksonville, Fla., March 8, on Spinal Conditions and Sero-Diagnosis.

W. C. Woodward attended the meeting of the New York Academy of Medicine, April 20, and made an address on "The Menace of Inadequate Quarantine" and "What An Efficient Quarantine Means to the Entire Country."

The Medical Society of the District of Columbia.

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To serve two years. John Van Rensselaer, J. S. Wall, W. P. Carr.
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SPECIAL COMMITTEES.

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Committee on Public Instruction.—L. B. T. Johnson, J. B. Nichols, W. M. Barton, Louise Tayler-Jones (representing National Committee on Public Health Education Among Women), L. H. Taylor (representing Committee of A. M. A. on Conservation of Vision).
Historical Committee.—D. S. Lamb, C. W. Franzoni, R. T. Holden, G. Wythe Cook, and Llewellin Eliot [Nov. 1, 1911].

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Ellison, Everett Ellerslie Monroe, Parrottsville, Tenn.
Ellyson, Robert Maitland, 1120 13th, n. w.
Emmons, Charles M., LL. M., 1100 Pennsylvania av., s. e.
Erbach, Amelia, 709 East Capitol.
Erving, Emma Lootz, A. B., 922 17th, n. w.
Erving, William Gage, A. B., 922 17th, n. w.
Evans, Warwick, 1105 9th, n. w.
Ferguson, Charles Emory, 1648 North Capitol.
Fillebrown, John Potts, M. E., Stoneleigh Court.
Finley, Clara Bliss, 1805 Phelps Place.
Fischer, Melville Bendheim, 1744 Lanier Place.
Fisher, Howard, A. M., The Mendota.
Fisher, Raymond Adams, 505 B, n. e.
Floria, Salvatore,
Hosp. Defect. Children, West Haverstraw, N. Y.
Flynn, James Augustin, 1232 Kenyon, n. w.
Folkmar, Elnora Cuddeback, 1818 N, n. w.
Foote, John A., 1716 M, n. w.
Foster, Romulus A., 2207 Massachusetts av., n. w.
Fowler, Henry Atwood, B. S., The Cumberland.
Fowler, William Chas., 1812 1st, n. w.
Fox, William Henry, A. M., 1826 Jefferson Place.
Foye, Amelia Frances, 1118 13th, n. w.
Frankland, Walter Ashby, The Champlain.
Franklin, Edmund T. M., 1315 19th, n. w.
Franzoni, Charles William, Ph. B,, 605 I, n. w.
Fremont-Smith, Frank, A. B., 1808 Massachusetts av., n. w.
French, William J., 1634 S, n. w.
Friedrich, Leon Leigh, 329 East Capitol.
Frischkorn, Robert W., 1242 Newton, n. e.
Fry, Henry Davidson, Sc. D., 1929 19th, n. w.
Fuller, Homer G., Ph. B., The Farragut.
Gannon, James A., 1219 Connecticut av., n. w.
Garnett, A. Y. P., 1214 18th, n. w.
Garrison, Fielding H., 2532 13th, n. w.
Gibson, Frank Eugene, 927 I, n. w.
Gill, William T., 442 M, n. w.
Gillette, Hubbard, 1930 8th, n. w.
Glascock, Alfred, Govt. Hosp. Insane.
Glazebrook, Larkin White, 2022 P, n. w.
Gleeson, James Knox Polk, 1451 Harvard, n. w.

Glueck, Bernard,	Govt. Hosp. for Insane.
Glushak, Leopold,	1440 R, n. w.
Goodman, Wm. R.,	1332 12th, n. w.
Graham, Neil Duncan,	The New Berne.
Graham, Neil Ferguson,	909 New York av., n. w.
Grasty, Thomas Sanford Dunaway,	1273 N. H. av., n. w.
Gray, Augustus C.,	3720 N. H. av., n. w.
Greene, Lewis Storrow,	1624 I, n. w.
Greene, Samuel H., Jr.,	1460 R. I. av., n. w.
Greene, Willard P.,	Dept. Health, Minneapolis, Minn.
Griffith, Chas. I.,	1371 Monroe, n. w.
Groff, Chester C.,	1107 I, n. w.
Groover, Thomas Allen,	The Iroquois.
Gunion, John Paul,	927 O, n. w.
Gunnell, F. M., U. S. Navy, Retired,	600 20th, n. w.
Gunning, Edward J.,	1210 Mass. av., n. w.
Gwynn, William Clarence,	1514 30th, n. w.
Haas, Carlton D.,	1302 Irving, n. w.
Hagner, Chas. Evelyn,	1207 Conn. av., n. w.
Hagner, Francis Randall,	The Farragut.
Hahn, Milton,	1219 Conn. Av., n. w.
Hall, Arthur Joseph,	625 I, n. w.
Hamilton, Ralph Alexander,	924 15th, n. w.
Hammett, Chas. Massey,	1330 I, n. w.
Hammond, Thos. Victor,	1713 H, n. w.
Hammond, Thos. Victor, Jr.,	1713 H, n. w.
Hardesty, Wm. S.,	The Wellington.
Hardin, Bernard Lauriston, B. S.,	1311 Conn. av., n. w.
Harding, Harry Theodore,	1459 Girard, n. w.
Harrington, Francis Edward,	1106 P, n. w.
Harrison, Bernard Hooe,	641 Mass. av., n. w.
Hart, James W.,	2156 F, n. w.
Hasbrouck, Edwin Marble,	4909 14th, n. w.
Haysmer, Elam Dolphus,	Sanatorium, Takoma Park, Md.
Hazen, Henry H.,	The Rochambeau.
Hazen, W. P. C.,	511 East Capitol.
Heiberger, Ida Johanna,	The Concord.
Heinecke, George Burton,	5634 Georgia av., n. w.
Heitmuller, Geo. H., A. B.,	1333 N, n. w.
Heller, Joseph Milton,	The Marlborough.
Hemler, Wm. F.,	706 8th, n. w.
Henning, Carl,	The Rochambeau.
Hickling, Daniel Percy,	1304 Rhode Island av., n. w.
Higgins, Daniel Witter,	653 East Capitol.
Holden, Raymond Thos.,	802 6th, s. w.
Holmes, Mary,	227 1st, n. e.
Hooe, A. Barnes,	1220 16th, n. w.
Hooe, Robert Arthur,	The Burlington.
Hornaday, Frank A.,	3509 14th, n. w.
Hornbrook, Frank Wheeler,	1836 Connecticut av., n. w.
Hough, William Hite, Phar. D.,	1801 K, n. w.
Howard, Stanton Wren,	1945 Calvert, n. w.
Hume, Howard,	1830 Jefferson Place.
Hummer, Harry Reid,	Canton, S. D.
Hunt, Arthur LeRoy, A. B.,	The Burlington.
Hunter, Montgomery,	1728 P, n. w.
Huntington, Wm. Henry,	1624 I, n. w.
Hurtt, Harry,	1524 P, n. w.
Hyatt, Franck,	The Rochambeau.
Hyde, Chas. Wilbur,	The Alabama.

Hynson, Lawrence Maxwell,	1335 N, n. w.
Irvine, Robert Steele,	Sanatorium, Takoma Park, Md.
Jack, William Alexander, Jr.,	1918 Biltmore, n. w.
Jackson, Virgil B.,	The Brunswick.
Jaeger, Henry W.,	424 East Capitol.
Jeffries, Joseph Arthur, Jr.,	901 20th, n. w.
Jenner Norman Richards,	1110 Rhode Island av., n. w.
Johnson, Henry Lowry Emilius,	1821 Jefferson Place, n. w.
Johnson, Joseph Taber, A. M., Ph., D.,	926 Farragut Square.
Johnson, Loren Bascom Taber,	2108 16th, n. w.
Johnson, Louis Alward,	200 8th, s. w.
Johnson, Paul Bowen Alden,	3208 17th, n. w.
Johnson, Stuart C.,	5214 14th, n. w.
Jones, Edward Barton,	1217 Connecticut av., n. w.
Jones, Thos. Glenn,	228 1st, s. e.
Jung, Franz August Richard,	1229 Connecticut av., n. w.
Jung, Sofie Amalie Nordhoff,	1229 Connecticut av., n. w.
Junghans, John Henry, A. M.,	417 D, n. e.
Karpeles, Simon Rufus,	1120 5th, n. w.
Kaufman, Harry Marx,	The Burlington.
Kaveney, Joseph J.,	The Elkton.
Kearney, Henry W.,	1229 O, n. w.
Kebler, Lyman Frederick,	1322 Park Road.
Kelley, John Thomas, Jr.,	1312 15th, n. w.
Kemble, Adam, Phar. D.,	The Cecil.
Kerr, Henry Hyland, C. M.,	1742 N, n. w.
Key, Sothoron, M. S.,	1716 H, n. w.
Keyser, Carl Schurz,	1218 19th, n. w.
Kilroy, James J.,	103 I, n. w.
Kimball, Arthur Herbert, B. S., A. M.,	The Farragut.
King, Ernest Frothingham, A. M.,	Bond, Building.
Kinyoun, Joseph James,	1423 Clifton, n. w.
Klemm, John Wm.,	2008 I, n. w.
Kober, George Martin, LL. D.,	1819 Q, n. w.
Koones, Charles Kneller,	20 Iowa Circle.
Kramer Thomas Best,	634 A, s. e.
Lamb, Daniel Smith, A. M., LL. D.,	2114 18th, n. w.
Lamb, Isabel Haslup,	2114 18th, n. w.
Lamb, Robert Scott,	The Cecil.
Larkin, P. Edward,	The Montana.
Lawrence, Albert Lynch, Phar. D.,	1330 Mass. av., n. w.
Lawson, Huron Willis,	1117 Vermont av., n. w.
LeComte, Ralph M.	1730 M, n. w.
Lee, Thomas Sim, A. B.,	1740 18th, n. w.
Leech, Daniel Olin,	1237 Massachusetts av., n. w.
Leech, Frank,	1372 Columbia Road.
Lehr, Louis Chas., A. B.,	1737 H, n. w.
LeMerle, Eugene Lyman,	2011 Q, n. w.
Lemon, Hanson Thos. Asbury,	903 M, n. w.
Lewis, Duff Green, A. B.,	1311 14th, n. w.
Lewis, Harry S.,	Emergency Hospital.
Lewis, Samuel Edwin,	1418 14th, n. w.
Lindsay, Janvier Whitton,	1808 Kilbourne Place.
Lindsey, John Hathaway,	Fall River, Mass.
Linville, Thos.,	905 10th, n. w.
Little, Arthur Bickle,	350 Cedar av., Takoma Park.
Little, Joseph W.,	1313 14th, n. w.
Little, Richard Mitchell,	1213 East Capitol.
Littlepage, Wm. Houston,	The Alabama.
Lochboehler, George John, Phar. D.	55 K, n. w.

Logie, Benjamin Rush,	The Brighton.
Loring, Frank Boot,	1420 K, n. w.
Lowe, Thomas F.,	205 H, n. w.
Luce, Charles Roscoe,	215 2d, s. e.
Luckett, L. Fleet,	1419 Rhode Island av., n. w.
Lynch, Robert L.,	3931 14th, n. w.
Lyon, Martha M. Brewer,	48 V, n. w.
McArdle, Thomas Eugene, A. M.,	1730 H, n. w.
McCarthy, Joseph J.,	1819 Adams Mill Road.
McCormick, John Henry,	1006 Selma street, Mobile, Ala.
McGuire, James Clark, A. M.,	1416 K, n. w.
McKay, James George,	2009 Columbia Road.
McKee, Wm. P.,	1634 S, n. w.
McKimmie, Oscar Addison Mack,	The Valois.
McLaughlin, Thomas Notley,	1226 N, n. w.
McLaughlin, Wm. F.,	103 R. I. av., n. w.
MacNamee, Arthur M.,	806 O, n. w.
McPherson, Dorsey Mahon,	1810 15th, n. w.
McQuillan, Francis	314 B, s. e.
Macatee, Henry Cook,	1478 Harvard, n. w.
Machen, Francis Stanislaus,	3206 17th, n. w.
Mackall, Louis,	3044 O, n. w.
Madigan, John J.,	The Congressional.
Madigan, Patrick S.	2302 Nichols av., s. e.
Magee, George H.,	604 H, n. e.
Magee, Michael D'Arcy, A. M.,	1623 Conn. av., n. w.
Mallan, Thomas Francis,	820 Connecticut av., n. w.
Mallory, Wm. J.,	1720 Connecticut av., n. w.
Malone, Wilson Prestman,	The Farragut.
Manning, Wm. J.,	The Alabama.
Marbury, Charles Clagett, A. B.,	1015 16th, n. w.
Marshall, Collins,	2507 Pennsylvania av., n. w.
Martel, Leon A.,	1339 Conn. av., n. w.
Martin, Thos. Chas.,	1725 N, n. w.
Martyn, Herbert Edward,	614 East Capitol.
Mason, Elijah Lumbia,	The Portner.
Mason, Robert French,	1431 21st, n. w.
Mason, Wm. Beverly,	1217 Connecticut av., n. w.
Masterson, Wm. Lincoln,	Stoneleigh Court.
Mazzei, Francis Anthony,	2 T, n. e.
Mead, Theodore,	928 23d, n. w.
Merrill, Walter Hibbard, B. L.,	Garfield Hospital.
Mess, Wm. A.,	459 G, n. w.
Metzerott, John Hitz,	1110 F, n. w.
Miller, Gideon Brown, B. Sc., C. E.,	1730 K, n. w.
Miller, Maurice Erwin,	1618 H, n. w.
Miller, Thomas,	1616 7th, n. w.
Miller, Thomas, Jr.,	3213 Georgia av., n. w.
Miner, Francis H.,	1842 16th, n. w.
Mitchell, James Farnandis, A. B.,	1344 19th, n. w.
Mitchell, Joseph Ernest,	510 13th, n. w.
Moore, Mead,	The Rochambeau.
Moore, Wm. Cabell,	The Wyoming.
Moran, John Francis, A. B.,	2426 Pennsylvania av., n. w.
Morgan, Edwin Lee,	The Plaza.
Morgan, Francis Patterson, A. B.,	1832 Biltmore, n. w.
Morgan, James Dudley, A. B.,	919 15th, n. w.
Morgan, Wm. Gerry, A. B.,	1624 I, n. w.
Morhart, Frederick H.,	1324 9th, n. w.
Morris George Gideon,	1913 14th, n. w.

Morse, Edwin Emery, 1706 M, n. w.
Moser, James Madison, 1219 Conn. av., n. w.
Motter, Murray Galt, A. M., B. S., 2314 19th, n. w.
Moulden, Wm. Raymond, Friendship Heights, Md.
Mudd, T. D., 1337 Good Hope Road.
Mulcahy, Daniel Dominick, Phar. D., 1216 North Capitol.
Muncaster, Steuart Brown, 907 16th, n. w.
Mundell, Joseph Joshua, 8 Maple View Place, Anacostia.
Murphy, Joseph Alexander, 919 L, n. w.
Murphy, Walter C., 507 4th, n. w.
Murray, Thomas Morris, Paris, France.
Neale, Richard A., 1209 U, n. w.
Neff, Wallace, A. M., University Club.
Neill, Thos. E., 1344 19th, n. w.
Neuman, Lester, 1509 16th, n. w.
Nevitt, James Ramsay, 1820 Calvert, n. w.
Newell, William Sawyer, The Champlain.
Newgarden, George J., A. M., 1633 Mass. av., n. w.
Newhouse, Benjamin, 1136 6th, n. w.
Nichols, John Benjamin, 1321 Rhode Island av., n. w.
Norcross, Alfred C., 819 Taylor, Petworth.
Norris, John Lawson, 2503 Rhode Island av., n. e.
Norris, Phebe Russell, The Iowa.
Ober, George Clarke, 125 B, s. e.
O'Donoghue, John Alphonso, A. M., 909 16th, n. w.
O'Malley, Mary, Govt. Hosp. Insane.
Ong, Harry A., 1768 Columbia Road.
Owen, Wm. Otway, 2719 Ontario Road.
Owens, Samuel Logan, The Plaza.
Pagan, Albert Elwood, 1624 I, n. w.
Parker, Edward Mason, 1726 M, n. w.
Parker, Henry Pickering, A. B., 1728 Connecticut av., n. w.
Parsons, Alfred Vandiver,
Takoma Park, D. C., Carroll and Maple av.
Parsons, Mary Almera, 937 New York av., n. w.
Patten, Wm. Francis, The Parkwood.
Perkins, Wm. Robert, Phar. D., 1332 15th, n. w.
Petteys, Charles Volney, 1211 Clifton, n. w.
Pfender, Charles A., 304 Rhode Island av., n. w.
Phillips, Wm. Fowke Ravenel, Mobile, Ala.
Pickford, Edward F., A. B., 422 8th, s. e.
Pigott, J. Burr, The Burlington.
Pile, Mayne Marshall, The Portner.
Pole, Samuel Boyce, 216 8th, n. e.
Polkinhorn, Henry Alexander, 1201 M, n. w.
Pool, Benjamin George, 945 Rhode Island av., n. w.
Poole, Thos. A., The Farragut.
Portman Adeline Elwell, A. M., Chevy Chase, Md.
Potter, James Albert, 300 2d, s. e.
Poulton, Wm. E., 227 4½, s. w.
Prentiss, Daniel Webster, B. S. 1213 M, n. w.
Price, Harry M., 1315 R. I. av., n. w.
Price, Malvern Hill, 5th and H, n e.
Prosperi, Milton Hickox, 216 8th, s. e.
Pyles, Richard A. 2015 Nichols av., Anacostia.
Ramsburgh, Jesse Houck, A. M., The Portner.
Randolph, Buckner Magill, The Toronto.
Ransdell, Robert C., P. A. Surgeon, U. S. Navy, Navy Dept.
Ray, Anthony Moreland, 4800 Wisconsin av., n. w.
Read, Boyd Richard, 123 R. I. av., n. e.
Ready, F. J., 819 North Capitol

Reede, Edward Hiram,	1748 M, n. w.
Reeve, Jesse Newman,	
Reeves, William Pinkney,	The Congressional.
Reichelderfer, Luther Halsey,	1721 Connecticut av., n. w.
Reisinger, Emory Wm.,	1228 16th, n. w.
Rench, Victor B.,	1313 Rhode Island av., n. w.
Repetti, Fred.,	811 L, n. w.
Repetti, Frederick Francis,	149 B, s. e.
Repetti, John Joseph,	404 Seward Square.
Richards, Alfred,	The Seward.
Richardson, Charles Williamson,	1317 Conn. av., n. w.
Richardson, Edward Elliott, M. S.,	1101 Alabama av., s. e.
Richardson, James Julius,	1509 16th, n. w.
Richey, Stephen Olin,	732 17th, n. w.
Riggles, John Lewis,	The Champlain.
Rives, Wm. C.,	1702 Rhode Island av., n. w.
Robins, William Littleton,	The Rochambeau.
Rogers, Joseph Decatur,	1400 M, n. w.
Roman, Frederick Ogle,	1337 R, n. w.
Rossiter, Thos. J.,	820 D, s. e.
Roy, Philip Seddon,	1200 Massachusetts av., n. w.
Ruble, W. A.,	Loma Linda, Cal.
Ruedy, Robert Conrad,	621 Maryland av., n. e.
Ruffin, George Mendenhall,	The Parkwood.
Ruffin, Sterling,	1235 Conn. av., n. w.
Russell, Murray A.,	1440 R. I. av., n. w.
Samson, George C.,	2423 Pennsylvania av., n. w.
Savage, Linnaeus Samuel,	623 Maryland av., n. e.
Sawtelle, Henry Fenno,	3001 11th, n. w.
Schaeffer, Edward Martin,	1808 G, n. w.
Schneider, Elwin C.,	1742 U, n. w.
Schreiber, H. R.,	502 H, n. e.
Scott, James Foster, A. B.,	McLean, Va.
Seibert, Edward Grant, Phar. G.,	1545 I, n. w.
Selby, John Hunter,	1621 Connecticut av., n. w.
Sellhausen, Harry A.,	640 G, n. w.
Sessford, Joseph S. F.,	1738 F, n. w.
Shands, Aurelius Rives,	901 16th, n. w.
Shaw, John Watson,	1453 Rhode Island av., n. w.
Shoup, Jesse,	The Roland.
Shute, Daniel Kerfoot, A. B.,	1719 De Sales, n. w.
Sillers, Robert Fry,	313 H, n. w.
Simpson, Chas. August,	1219 Connecticut av., n. w.
Simpson, John Crayke,	1421 Massachusetts av., n. w.
Skinner, J. O.,	Columbia Hospital.
Sloat, Jessie Irving,	The Congressional.
Smart, Benjamin Horace,	227 Rhode Island av., n. w.
Smith, Dwight Gordon, A. B.,	1421 Columbia Road.
Smith, Percy G.,	1489 Newton, n. w.
Snowden, Edgar,	1900 S, n. w.
Snyder, Arthur Augustine,	1126 16th, n. w.
Sohon, Elizabeth,	512 I, n. w.
Sohon, Frederick,	512 I, n. w.
Sorrel, George R.,	616 F, s. w.
Sothoron, Elmer Hezekiah, B. E.,	1921 I, n. w.
Sowers, Wm. F. M.,	1707 Mass. av., n. w.
Sowers, Zachariah Turner, A. M., Ph. B.,	1707 Mass. av., n. w.
Spire, Richard Lee,	1609 North Capitol.
Sprigg, William Mercer,	The Rochambeau.
Squire, Susan Johnson,	Percival Hotel, Los Angeles, Cal.

St. Clair, Francis Alphonzo, Phar. D.,	1319 T, n. w.
Stanley, A. Camp,	826 Connecticut av.
Stanton, Wm. Joseph,	3323 O, n. w.
Staples, Aubrey Horatio,	1739 S, n. w.
Stavely, Albert Livingston, A. M.,	1744 M, n. w.
Steltz, Peter Henry, Jr.,	611 North Carolina av., s. e.
Stephenson, Eugene Theodore,	653 Maryland av., n. e.
Stewart, John W.,	1202 K, n. w.
Stewart, Margaret Ross,	1713 I, n. w.
Stone, Charles Granville,	5756 Georgia av., n. w.
Stone, Isaac Scott,	Stoneleigh Court.
Stoutenburgh, John Albertson,	116 2d s. e.
Strobel, Mary Louise,	16 R, n. w.
Stromberger, Henry Holliday,	135 Florida av., n. w.
Stuart, Albert Rhett, A. M.,	1638 Connecticut av., n. w.
Stuart, James, A. B.,	1315 12th, n. w.
Suddarth, James Littleton,	609 M, n. w.
Sullivan, Robt. Young,	The Burlington.
Suter, Henderson,	3026 N, n. w.
Sutherin, John Wesley,	3525 14th, n. w.
Swain, Oliver A. T.,	321 E, n. e.
Syme, Wm. Henry,	14th and Fairmont, n. w.
Talbott, John Allan,	1918 I, n. w.
Tastet, David W.,	2821 11th, n. w.
Tayler-Jones, Louise, M. S.,	1217 Connecticut av., n. w.
Taylor, Eugene Arthur,	The Montana.
Taylor, Lewis Harvie,	The Cecil.
Tewksbury, W. D.,	4200 Georgia av., n. w.
Thomas, Ada Rebecca,	The Thomas.
Thomas, John Daniel, A. B.,	1726 M, n. w.
Thomas, Wm. J. G.,	2905 14th, n. w.
Thompson, Edgar Dorman, A. M.,	Wardman Courts.
Thompson, Joseph Ford,	Cosmos Club.
Thompson, J. Lawn,	The Cumberland.
Thompson, Millard Filmore, D. D. S.,	484 Md. av., s. w.
Thomson, Lewis Beecher,	3423 16th, n. w.
Thönssen, Wm. Julius Reichmann,	315 C, s. e.
Tibbits, Albert Perkins,	The Laclede.
Titus, Elijah White,	1730 M, n. w.
Tobias, Henry Wood, B. E.,	1339 Columbia Road.
Tobin, Richard F.,	123 11th, s. e.
Trimble, Robert S.,	722 18th, n. w.
Tubman, James Richard,	1750 Park Road, n. w.
Upham, W. C.,	128 Maryland av., s. w.
Vale, Frank Palmer,	208 Southern Building.
Valentine, Aloysius W.,	610 North Carolina av., s. e.
Van Rensselaer, John, A. M.,	The Rochambeau.
Vaughan, George Tully,	1718 I, n. w.
Verbrycke, J. Russell, Jr,,	The Rochambeau.
Vincent, Thomas Norris, A. M.,	The Mansfield.
Wagner, Wm. F., Phar. G.,	501 L, n. w.
Walker, Allen,	739 Quebec, n. w.
Walker, Reginald Redford,	818 17th, n. w.
Wall, Joseph Stiles,	2017 Columbia Road.
Walsh, Ferdinand Claiborne,	Moore Bldg., San Antonio, Tex.
Walsh, John Edgar,	127 Florida av., n. w.
Walter, William Francis, A. M.,	487 H, s. w.
Warner, John W.,	128 East 60th, New York City.
Warren, George Walter,	1212 H, n. e.
Waters, Charles L.,	1414 Q, n. w.
Watkins, Edgar Wm.,	1373 Columbia Road, n. w.

Watkins Samuel Evans, 1115 O, n. w.
Watson, James A., 201 Nichols av., Anacostia.
Weaver, Clarence Arlington, 1614 Q, n. w.
Webb, Newton E., 1314 East Capitol.
Webb, Walter Duvall, 1803 Connecticut av., n. w.
Wellington, John Ryder, A. M., 1723 Connecticut av., n. w.
Wells, Walter Augustine, The Rochambeau.
Werber, Gustavus, A. M., 1353 Q, n. w.
West, Richard Thomas, 2519 14th, n. w.
Wharton, John J., The Northumberland.
Wheatley, Charles, The Montana.
White, Charles Stanley, 911 16th, n. w.
White, Davenport, 1217 Conn. av., n. w.
Whitson, Wm. E., 929 M, n. w.
Wilkinson, Oscar, 1408 L, n. w.
Wilkinson, Walter Watkins, Cumberland, Va.
Williams, Tom A., 1705 N, n. w.
Willson, Prentiss, 1732 Connecticut av., n. w.
Wilmer, William Holland, 1610 I, N. W.
Wolfe, James Thruston, 1843 Calvert.
Wood, George Wm., 2906 P, n. w.
Wood, Wm. Pleasant, 227 B, n. e.
Woodman, Francis J., 634 A, n. e.
Woodward, Wm. Creighton, LL. M., 1782 Lanier, n. w.
Wright, Hamilton K., Livermoor Falls, Me.
Wynkoop, James C., 1431 R. I. av., n. w.
Yarnall, John Hepburn, 3028 P, n. w.
Yarrow, Henry Crecy, 926 17th, n. w.
Yates, Frederick, LL. M., 1230 9th, n. w.
Young, Clifton E., Spokane Agency, Lincoln, Neb.
Young, Wm. Glenn, 1523 L, n. w.

Honorary Members.

1895—Ashby, Thomas A., 1125 Madison av., Baltimore, Md.
1900—Jacobi, Abraham, 19 East 47th, New York City.
1905—Keen, W. W., 1719 Chestnut, Philadelphia, Pa.
1895—Osler, William, Oxford, England.
1895—Palmer, W. H., 274 Broad, Providence, R. I.
1895—Shattuck, Frederick C., 135 Marlboro, Boston, Mass.
1895—Sternberg, George M., Surgeon General, U. S. A., ret., 2005 Massachusetts av., n. w., Washington, D. C.

Associate Members.

Alsberg, Carl Lucas, Bureau Chemistry, Dept. Agriculture.
Bloedorn, Walter A., U. S. N., U. S. Navy Yard.
Braisted, Wm. C., Surgeon General, U. S. Navy.
Bullard, Ernest Luther, Rockville, Md.
Christie, Arthur C., Captain, Medical Corps, U. S. A., Army Medical School.
Evans, Sheldon G., U. S. Navy, San Diego, Cal.
Fadeley, George B., Falls Church, Va.
Ferrell, John Atkinson, Southern Building.
Fisher, Henry C., Lt. Col., M. C., U. S. A., Walter Reed Hospital.
Griffith, W. Allen, Berwyn, Md.
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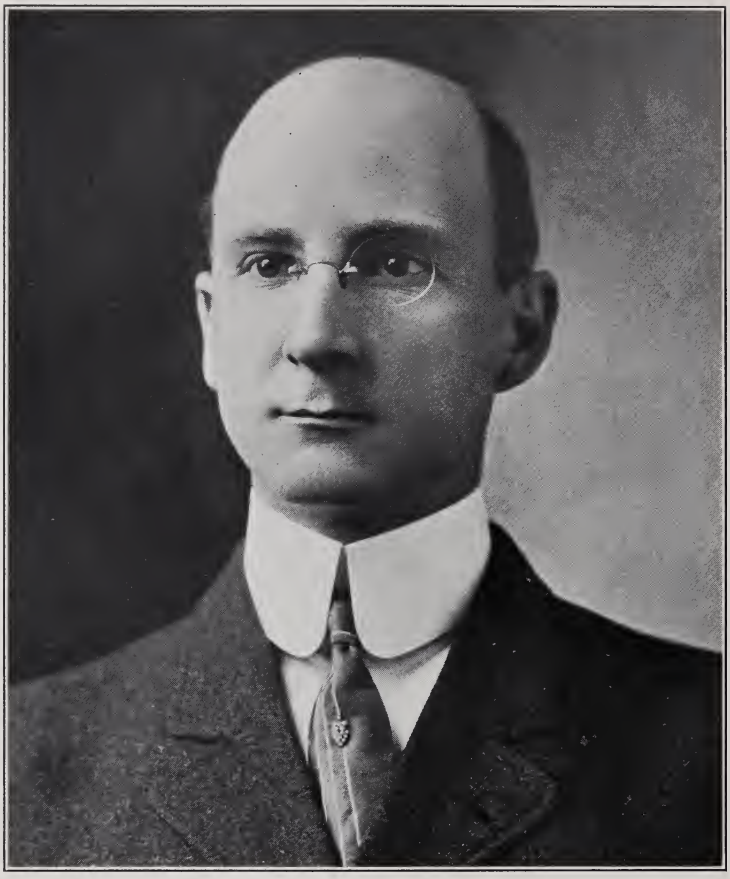

DR. ERNEST PENDLETON MAGRUDER.

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THE OPIUM HABIT AND ITS TREATMENT.*

By D. Percy Hickling, M. D.,
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In examining the annual reports of the Washington Asylum Hospital from 1898 to April 15, 1915, I find that there were 372 patients treated for Morphinism or Morphinomania; the Levinstein term being the most descriptive of the craving experienced by a person who has formed the habit of using opium or any of its derivatives.

I have examined five of the reports of that institution prior to 1898, beginning with 1892, when Dr. Dyer was in charge, and there was no attempt made to indicate the diagnosis of a case admitted into that institution, except to give the cause of death. For the fiscal years ending June 30, 1898 and 1899, the records do not give the sex and color classification nor do they show the results of the treatment. During these two years 21 cases of morphinomania were treated. The records for the fiscal year ending June 30, 1915, have not yet been completed, but from June 30, 1914, to March 1st, the date on which the Harrison law went into effect, there were 42 cases admitted, and from March 1st to April 15th there were 48 cases admitted for treatment.

Excluding the fiscal years 1898, 1899 and 1915 we find a fifteen-year period in which the records are complete and accurate; during this 15-year period 246 cases were treated. This number does not show by any means the number of patients treated who used opium or its derivatives as a habit, but only the cases where morphinomania was the chief symptom, and where treatment was given and results recorded; many of these cases of course suffered with other conditions which were serious enough to require treatment, and in several cases there were contributive factors to the cause of death, although the records show that the death was caused by morphinism. Again, these figures do not show the number of cases in which morphine was given in regular and increasing doses for the relief of pain in incurable disease.

Of the 246 cases, 127 were white males, 102 white females, 24 colored males and 8 colored females; of this number 89 were

*Read before the Medical Society April 28, 1915.

cured, which was a little more than 36 per cent. of the cases treated; 110 were improved, 34 unimproved and 14 died. The number recorded as improved and unimproved amounted to about 58 per cent. of the cases, and under this heading were classed those who left the hospital before the drug had been entirely withdrawn from use; in all cases, of course, the quantity of the drug used had been reduced to a greater or less extent. The number of deaths during this 15-year period amounted to a little less than 6 per cent. of the cases treated, and, as before noted, in all of these cases the previous physical condition of the patient contributed largely to the fatal result.

In compiling a chart showing the number of cases admitted by months during this 15-year period there are four distinct rises in the curve, namely, in 1904, 1907, 1910 and 1914. I am at a loss to account for the increase in numbers in 1904, 19 cases; that in 1907, 24 cases, was evidently due to the enforcement of the pharmacy law. At that time the rapid withdrawal method was used, which caused the patient great mental suffering, and as it was soon found that the drug could be readily obtained and that the law was practically ineffective, for the next two years the number of admissions materially decreased. The rise in 1910, 24 cases, was evidently due to the use of the Towne treatment at the hospital, which gave a larger percentage of cures than had been obtained prior to this form of treatment being used; again, there was a two-year decline until the agitation created by the Harrison law began to be effective and the beneficial effects of the Towne treatment appreciated.

By far the largest number of cases that have come under my notice, not only at the Washington Asylum but in private work, have used the sulphate of morphia by the hypodermic method. No matter what preparation of opium they began with or how the habit first started, they have usually reached the hypodermic method sooner or later. Again, the vast majority of cases do not confine themselves to one method or one form of the drug through their habit life, so that they frequently take it by mouth or by nares, and they often change from morphine to heroin or laudanum and usually add cocaine and alcohol to their dissipation; the cocaine and alcohol producing the excitement which is so often denied them when they use the opium exclusively, the effect of opium being a condition of euphoria and contentment but not of exhilaration. The average dose used by the hypodermic method is about 15 grains per day, although as high as 75 grains have been used in 24 hours; it is usually taken three times a day, although when more than 15 grains are taken, it is usually used much more frequently on account of the solubility of the drug. I have seen 60 grains taken at one dose by mouth in several cases. All the cases using the larger doses have commenced with small doses but had to increase the dose from time to time or they

would suffer from the craving for the drug, and general disturbances, such as tremor, nausea and vomiting, and excessive coughing; these symptoms together with the lack of contentment and well-being which the drug has usually produced, soon lead to the increase in the quantity or frequency of its use.

The demoralizing effects upon those who use the drug in any quantity for any length of time are well known; they become incapable of mental activity, of attending to business affairs; they become untrustworthy and are not true to themselves or others. The moral sense becomes deteriorated and sometimes a toxic psychosis develops, in which drowsiness, sensory hallucinations and mental confusion occur.

After a person has used the drug for some months, symptoms due to chronic morphine poisoning occur; the fatty tissues gradually disappear, the skin becomes flaccid, the face pale, ashen grey or sometimes a dark red; digestive disturbances, comprising a loss of appetite and irregular bowels; cardiac weakness, tremors of various kinds with general muscular weakness, diminished sensibility, paraesthesias and disturbed menstrual functions, the pupils being small and reacting sluggishly to light. On the mental side the patient is depressed, memory impaired, with loss of initiative, gradual moral deterioration, and paranoid hallucinations; a propensity for lying and stealing, and even the occurrence of epilepsy; their irritability, diminished power of attention and easily excited temperament render them unable to cope with the affairs of life or to adjust themselves to an environment so that they may best serve their interests in life and those dependent upon them. An extra dose or an increase in the quantity will often bring them back to an apparently normal condition only to see them return after its immediate effects have worn off, until finally a condition of marasmus develops and brings about a fatal termination. It will thus be seen that the condition of the user is a deplorable one when taken in its entirety. He cannot live without the drug and he cannot live with it, and during its use he is at best an undesirable member of society, although on cross section the case may appear to be doing fairly well if he is only allowed to continue his habits; this, of course, is more apparent than real.

Since the enactment of the Harrison law, judging from personal talks with leading physicians and from reading a number of communications published in the *Journal of the American Medical Association*, it would seem that there is an inclination in the minds of many physicians to accept the dictum that of two evils they should choose the lesser, as they seem to think it is better to aid the unfortunate in the continuation of his habit than to attempt to cure him. This attitude is probably the result of two conditions; first, that in the past the number of persons who would return to the use of the drug after they had been cured was so great that

the physicians were probably justified in hesitating in advising that a cure be undertaken. According to Oppenheim, out of 82 males cured, 61 relapsed, and of 28 females, 19 returned to their habit; of 32 physicians who were cured, 26 resumed its use. Knowing as they did that the methods of cure were expensive and required considerable suffering on the part of the patient, very often it seemed as though time and money were wasted, and many in the profession believed that the best thing to do was to continue the patient in the moderate and temperate use of the drug. It is very fair to suppose that in the future, according to the difficulty in obtaining the drugs, relapses will necessarily be less numerous.

The second condition is that the physician is apt to yield to the excuses given by the patient who claims that he is unable to stop its use, to stop it would kill him, that the satisfaction which the use of the drug affords enables him to continue his work, and he even goes so far as to claim that he is better off when he takes it; and in other instances it often happens that cures are undertaken more from the desire to please the friends than the patient. The only disadvantage ever claimed is the expense of the habit, although upon this question the user usually finds but little fault. These statements and statistics, however appealing they may be, are deceptive, and in no case should be accepted by the physician without proper consultation with one competent to judge of the conditions, and when this consultation is called the "Cure of the habit or the treatment, injury or deformity," will be the only question considered, as the law of May 7, 1906 distinctly says that it can be "for the above purposes only" and "no other purpose whatsoever."

One of the many benefits resulting from the so-called Harrison Act has been the calling attention to the abuse in the use of opium and its derivatives, morphine and heroin. It has been evident for many years that the number of persons addicted to the use of these habit-forming drugs was on the increase, not only among the well-to-do and aged, but among the pauper, criminal, ne'er-do-wells and younger members of our community. This I believe to be true of all the other large cities in the United States, as well as in the District of Columbia. This army of unfortunates has increased from year to year, and while the injurious effects of the drugs have been known, yet practically nothing was done in the District of Columbia until the Act of May 7, 1906, which made it an offense to sell opium or its derivatives within the District without a physician's prescription; and this same Act made it a misdemeanor for any physician to prescribe these habit-forming drugs except for the relief and cure of his patient. Prior to this time these drugs were sold by the druggist as freely as castor oil or quinine, provided the druggist would keep a record of his sales.

When the above-mentioned law went into effect there was great uneasiness in the minds of those who had been using these drugs, but they soon found that they could be secured through a physician's prescription, which could be easily and often cheaply obtained ; and upon the most flimsy excuse many of our druggists would furnish opium or heroin to the insistent user. Again, the restrictions of this law semed to create an opportunity for unprincipled men and women, not connected in any way with either medicine or pharmacy, to obtain large supplies of the drug, and to sell it at enormous profits to users, who believed that they were getting it in spite of the law and in the easiest way, so that prior to March 1, 1915, it was easy for one to obtain the drugs desired, and it is no wonder that the number of users continued to increase in the District of Columbia. The condition was practically worse than it had been previous to the restrictions imposed upon it by the act of May 7, 1906, but now when this act is enforced in connection with the Harrison law, the District of Columbia now has become legally a prohibited district, and prosecution will, I believe, be easy and frequent in case the law is violated, the Harrison law merely making a traceable record from the producer to the ultimate consumer.

I have attempted to obtain from a large number of persons addicted to drug uses the reasons which prompted them to use the drug for the first time, the reasons for persisting in the use, and the effect which it has upon them. A few of the persons with whom I have talked blame companions both male and female for not only persuading them to use it, but giving them a supply which in some instances has been of sufficient quantity to enable them to form the habit. With these few exceptional cases the larger number unhesitatingly blame the medical profession for starting them in the habit ; this charge, while generally and thoroughly believed to be true, is unjust and when analyzed found to be false. The story invariably follows this formula : they were sick and suffering ; a physician was called who prescribed for them, and they obtained relief ; but either their pains would return or, as many unhesitatingly declare, they obtained such pleasant relief that they continued to have their prescriptions renewed until they ascertained the fact that they were obtaining relief and comfort through the use of opium or morphine, when they would purchase the drug itself in order to obtain the advantages of its effects, without the other ingredients in the prescription. And then by means of suggestion or experiment the syringe was substituted for the oral method of use, so that while the physician is blamed, he is entirely innocent of the intent which has led to such disaster.

When these facts are taken into consideration I think it becomes the duty of every physician to advise, at whatever cost, the cure of the habit, and now under the restricted and I hope

prohibitive laws which are in force, will prevent the return to the habit, even though the patient may so desire.

In considering the methods of cure, we have at our disposal three methods, which differ somewhat in their detail; these are known as the gradual, the immediate and the rapid. The choice depends somewhat upon the patient's condition, his age and his environment. In considering any method of cure there are two clinical conditions which must be kept in mind, when you attempt to stop or even diminish the amount of the drug which is being used, namely, the mental distress and the physical distress.

The mental distress is entirely subjective and may be either communicated by the patient or concealed, according to his mental attitude towards the cure; if he is trying to coöperate with you earnestly he will conceal it; if he is opposed to the treatment he will complain bitterly of his feelings for the purpose of getting you to give him the drug.

The physical symptoms are objective and consist of increase in the rapidity and weakness in the action of the heart, vomiting, diarrhoea, and general muscular tremors affecting the extremities. The subjective symptoms may be in some cases ignored, but the objective symptoms should never be permitted to appear, and if one or more of them should develop they should be treated promptly, as they not only interfere with the treatment but may produce collapse and death of the patient. Especially is this true in senile cases or where the patient is in a weak and debilitated physical condition.

Another point which should be kept in mind in selecting the method of cure is the way in which the patient is using the drug as well as the form of opium taken. The drug is used by inhalation, smoking, by the mouth or hypodermically, and opium either plain or in combination, morphine, heroin or codein are the drugs generally used. The rapid method of treatment is probably the one to be selected in the largest number of cases. Where the patient is in good physical condition and under 60 years of age this method is to be used and consists of the "Towne" treatment, the details of which are probably familiar to you all. The amount or kind of drug taken or the method of taking it is not to be considered where the rapid withdrawal method is used; the patient must be in all cases under the constant care of a competent and trustworthy nurse, familiar with the details of the treatment, and preferably in an institution; but under all circumstances he must be under complete physical control, as this treatment does not prevent the subjective suffering of the patient until after or during the second day, and occasionally I have found the appearance of the objective symptoms to require a cessation of the treatment for two or three days, where it has been my custom to administer small doses of morphia hypodermically sufficient in quantity and frequency to cause the objective

symptoms to disappear, this quantity and frequency being in all cases a very small part of the original dose which the patient had been accustomed to take. Then at the end of two or three days I again begin the treatment when the patient has lost entirely the mental and physical symptoms due to the withdrawal of the drug, and merely needs rest, food and tonics to enable him to regain his normal mental and physical condition.

The immediate withdrawal of the drug was one which I used by preference before I became acquainted with the Towne treatment. This is given under the same precautions concerning control and nursing as the Towne treatment. The drug is withheld until the first appearance of the objective symptoms, when a minimum dose of the drug is given which the physician believes will prevent the further development of the objective symptoms; this dose is best given hypodermically, and should not exceed two grains; the patient is then allowed to go until objective symptoms are again impending, when a smaller dose, usually one-half of the first dose, is given, and so on until the objective symptoms are entirely eliminated. While this treatment is going on the patient is given sedatives consisting of luminal, trianol, hyoscyamus, with hydrotherapy, and stimulants of either camphor, ergot or strychnia, and with plenty of light, nourishing and digestible food. Under this form of treatment the patient is usually at the end of four days enabled to go entirely without the drug; the after treatment being the same as in the rapid method. This treatment is severe and the patient suffers considerably, and even for some time after the withdrawal of the drug he still has cravings for his accustomed dose and has to be under some supervision for some time. A number of physicians believe that in the severity of this treatment and suffering incurred by the patient, there is an advantage that prevents by its memory the return to the use of the drug after the cure has been completed.

The gradual method of cure has its advantages in the fact that it prevents the disagreeable experiences of the subjective as well as the objective symptoms of withdrawal of the drug and should be used in weak and debilitated patients and in senile cases. The objection to its use is that it requires nursing supervision from six weeks to three months. This gradual cure can be given either by the mouth or hypodermically. When given hypodermically a 4-ounce bottle should be prepared so that the usual dose can be given; for each dose removed from the 4-ounce bottle a like quantity of sterile water is put into the bottle to dilute the original dose; this is kept up as long as the patient is fairly comfortable. On the first appearance of subjective symptoms the dose is continued at the same rate for one or possibly two days; this is brought about by failing to add the sterile water to the original mixture; in this way the treatment is continued until $\frac{1}{120}$ of a grain is given in 24 hours, when it can be stopped altogether

without discomfort to the patient. During this treatment I usually give nitrate of strychnia with belladonna, ergot, or hyoscyamus by the mouth, as the condition may require; the patient is fed liberally and takes plenty of exercise and usually performs all customary duties; the bowels are kept in good condition, salines to be used when required. The principal need of the nurse is to have charge of the drug and to use judgment, under the direction of the physician, as to when the reducing shall be stopped or continued.

When this gradual treatment is used by the mouth the following prescriptions are used*: No. 1, sulphate of morphia *q. s.*, alcohol 8 ounces, tincture of gentian comp. 10 ozs., tincture of ginger 7 ozs., and water 25 ozs.; mix and give two teaspoonfuls after each meal. Prescription No. 2, extract of cannabis indica 5 drams, glycerine 20 ozs., alcohol 18 ozs.; 2 teaspoonfuls to be placed in No. 1 after each dose. This treatment by the mouth is augmented by either spartein or strychnia if the heart shows weakness, and stomach conditions must be treated as they appear. In preparing the mixtures containing the morphia the treatment can usually be commenced by reducing the quantity of morphia to one-third of the original dose; this has the advantage of shortening the time, but sometimes causes mental distress on the part of the patient, which, however, usually subsides as the treatment is continued.

With these three methods I have never found a case too old to take the treatment, nor have I hesitated where excessive doses have been taken. I have seen a very old lady taking 60 grains of morphia a day entirely cured by the gradual method, and several cases to which I have given the rapid method of treatment were taking 15 grains a day.

In closing this paper it may be well to mention some of the causes which I believe have acted as potent factors in causing a return to the drug habit. A few cases have a return of pain due to physical conditions which should be relieved by operation or otherwise; the principal of these are gastric ulcer, neuralgia and dysmenorrhoea. Secondly, the association with bad company—persons who have been a habitué's companions and participated with him in the use of the drug; 3d, and which I believe to be the greatest cause, is mental depression, whether resulting from worry or grief, loss of position or a feeling of incompetence to cope with the affairs of life; this accounts, in my judgment, for the frequent use of the drug among mental defectives. It is often a defense reaction which removes the unfortunate from the world of reality, which is not congenial to him, and for which he is unfit, and transfers him to the land of dreams where wishes

*F. H. Hubbard. The Opium Habit and Alcoholism.

become realities. In this class of cases, which are not few in number, psychoanalysis and the judgments obtained through psychotherapy bring about the most brilliant and permanent results.

Dr. Reisinger had been treating cases of opium habit for about twenty years. He had not had much success with the rapid withdrawal method; but the gradual method in his hands had been very satisfactory. He had evolved a plan so gradual and so simple that the patients do not know at all that the drug is being withdrawn. He takes over the responsibility of purchasing the drug and of administering it; the dose is reduced every five days, continuing the reduction until the twenty-four hours dose is 1/200 gr; then a placebo tablet is substituted and given for ten days when the patient is made acquainted with the fact that no opium is being taken. (He cited several cases treated in this way.) He expressed the opinion that such cases must be followed up for a long time before the permanency of the cure can be regarded as certain.

He complimented Dr. Hickling upon his presentation of the subject. The Harrison law will certainly help and largely so because it drives the opium habitues to seek treatment.

Dr. P. B. Johnson recalled Dr. Hickling's statement that morphia addicts often add cocain to their indulgences. He had seen the statement that morphin habitues cannot use cocain; would Dr. Hickling speak more fully on this point?

Dr. Chipman spoke of a case recently discharged from the Washington Asylum Hospital as cured of the opium habit; he had seen this patient recently purchasing paregoric. Doctors are themselves much to blame for many cases of opium habit. The Harrison law will serve to cut prescription refills twenty five per cent. An examination of any druggist's files will show that many physicians prescribe morphine largely and frequently.

Dr. Chappell said that the subject is just now one of very great importance. He had had to treat two persons recently, driven to seek his aid because since the Harrison law they were no longer able to secure opium; they had been addicted to the use of the drug for thirty years. What can the physician do in the case of persons addicted for so long a time? Shall we continue the habit or shall we attempt to cure it? If we are made of the right stuff we will seek to cure it. The law of 1906 makes it incumbent on the physician to prescribe opium only for the cure or alleviation of disease. This should provide the necessary check. What can be done if physicians take refuge in actions under the law of 1906 behind the defense of professional secrecy? Personally he hoped that the laws would prove sufficient to accomplish their purpose.

Dr. S. S. Adams said that if the Harrison law will do nothing else it will stop the indiscriminate refilling of prescriptions. The weakness of the law was suggested by Dr. Chappell; lawyers

state that the code will sustain a physician's plea of privileged communication. The Harrison law is an effort in the right direction. Dr. Adams had long since abandoned trying to cure opium addicts, because he had found that they always got the drug in spite of his efforts. As to the Lambert treatment, he had seen it applied to a young man who had been taking opium for eighteen years; one of Lambert's nurses came down and took charge of the treatment; the result was satisfactory. Physicians when approached by addicts must take the position that they are not dispensers of drugs; that they will not use their privileges to keep people drunk on drugs, and that if their help is to be secured the patient must submit to cure.

Dr. Atkinson said that the code will not protect physicians on the ground of privileged communications, because the Harrison law is a federal law. It is possible to treat opium addicts at home as he had proved by a number of successful cases. He prescribed the drug himself and reduced it by serial dilution. Some patients will discontinue treatment when the reduction becomes uncomfortable and will go to another physician and apply for treatment as a new case; physicians should be on guard against imposture of this sort.

Dr. Williams said that one could wish that the confidence expressed by the last speaker could be justified by experience. It has been found that it is easy to get these patients down to two grains, but below that point a metabolic need is felt and this leads to an unrest which produces a new craving. There is also often a psychic basis for the addiction which will require a very skillful psychotherapy to control; this is not within the grasp of most physicians. It is more or less easy to get these patients off the drug, but unless we can alter the environment and give necessary moral support in times of stress, we should stand in daily fear of relapse. Moreover if denied their accustomed solace these psychic degenerates will resort to other psychopathic outlets.

Dr. Hickling said that a practical point to remember is the grim joke that the only restriction upon physicians is the law of 1906; the Harrison law does not restrict the physician whatsoever, but it does provide a means to trace every transaction of doctors in the narcotic drugs. Opposition to the law on the part of the profession is based on a false sympathy for drug addicts or on a desire to profit by their misfortunes. There remains a loophole in the law, viz., the exemption of paregoric and the eighth grain limit; this was a concession which the patent medicine people were able to obtain.

The causes of the symptoms of withdrawal are interesting and obscure. He was interested in Dr. Reisinger's method of reduction; his own experience, however, has been that the nurse must be in charge to observe the objective signs of withdrawal.

Patients do not usually take morphine and cocaine together; they switch from one to the other, with alcohol as a third alternative refuge.

With regard to Dr. Williams' statements about the influence of environment and the need of psychotherapeutic measures in these cases, there can be no doubt about the importance of these influences. The drug habit is a form of defense reaction: a gentleman through his own fault is reduced to vagabondage; he hates himself and through opium or alcohol seeks nepenthe. This is a gross illustration of what happens in many psychopathic weaklings, who flee to drugs to escape an unbearable reality. They must be built up to sustain real life; some it is impossible to help and such belong in institutions.

A REVIEW OF THE ADVANCE IN THE KNOWLEDGE OF THE THYMUS GLAND.*

By Edward Hiram Reede, M. D.,

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During the past year, in the course of an attempt to interpret certain phases of the clinical expression of perversion in the secretion of the thyroid gland, I have had occasion to follow rather closely the contemporary medical literature appearing upon the rather modern subject of the glands of internal secretion, and have been impressed by the coming into prominence as a factor, and in some cases not only as a factor but as a dominant principle, of a gland which has hitherto been considered to merit but scant consideration by the authors of textbooks on physiology, surgery and clinical medicine, and that gland is the thymus.

One cannot avoid being impressed by the reports of men whose words are authoritative in lines of experimental research as well as surprised by the rational realignment in a new context of certain hitherto observed clinical facts at the hands of the men of wide clinical repute.

At first I approached this subject in a manner not unlike the advance of Alice in the familiar book of Lewis Carroll's, upon the cake which was lying under the table, at what time she had inadvertently come upon the Adventure of the Rabbit Hole. As you will recall, this small cake had the words "Eat Me" tastefully traced upon it in currants. And Alice, after some thought, said, "Well, I'll eat it, and if it makes me grow larger I can reach the key, and if it makes me grow smaller I can creep under the door; so either way I'll get into the garden."

* Read before the Medical Society May 26, 1915.

However, I became profoundly interested in what I read, and those of my friends who would listen to me readily became argumentative, which is an earmark of interest, and I thought that the Society might find something of worth in a brief paper, which makes no pretense to any original presentation, but will attempt to correlate in coherent form the scattered reports of accepted work appearing in the recent literature.

The consideration of the thymus as a regulator of fetal growth alone, a gland which attained its acme of development as a rule at birth, and rapidly deteriorated after the age of two years, which was my student information regarding it, came to be modified later by the apparently wide belief that its potency remained unimpaired until puberty. However *Fenger* of Chicago (*Jour. of Biolog. Chem.*, Balt., Feb., Vol. xx, No. 2, p. 97), basing his belief in the gland's activity upon its content of phosphates and nuclein bodies, finds that it is active in the fetus three months before maturity; and although in fetuses and young growing animals the thymus tissue is greater per unit of weight than in adults, yet he finds this evidence of function in fully matured animals during their reproductive life.

A gland, too, that possesses the potentiality of hypertrophy in adult life must, I think, be reasonably assumed to be more than an atrophic remnant. This hypertrophy consistently does occur in certain diseases of adult life. You will find it noted among Cushing's cases of posterior lobe deficiency in pituitary disease. Crowe found it recorded in all cases of Addison's disease listed in the Pathological Department at Johns Hopkins, and Halstead says that it has been found in 82 per cent. of exophthalmic goitre patients dying of some other disease.

For some years the German school, as represented by Klose, have asserted not only that the thymus was essential to life, and that removal induced gradually fatal symptoms, but that an experimentally-produced deficiency gave rise to bone changes not distinguishable from rickets. Many attempts at rachitic therapy since that time have been based upon that assumption. At the meeting of the American Pediatric Society, May, 1914, Dr. Howland, of Baltimore, verbally reporting some experimental work done by his assistants Park and McClure, said that after complete extirpation of the thymus the animals not only did not die, but they showed no signs of rachitis; and, what was especially noteworthy, at the end of six months, although the dogs were active, healthy looking, perfectly formed animals, yet they were but half the size of the unoperated controls; they were, in fact, *dwarf dogs* (*Jour. Am. Med. Assoc.*, lxiii, 1–132; Klose, *Jahrbuch f. Kinderheilkunde*, Dec., 1913). This work has been confirmed, apparently, by Pappenheimer; (*Jour. of Exper. Med.*, xx, 5–433.)

With this in mind, the work of Gudernasch, of the Department

of Anatomy of the Cornell University Medical School in New York in 1912, takes on a definite meaning. While working with the tadpoles Dr. Gudernasch found that by feeding them on any other food *except thyroids* these tadpoles would reach a maximum size in about ten weeks, and that then differentiation began independently. When fed upon the *thymus* of calves, however, they experience a rapid growth, but fail to develop their hind legs, even though they grow to a size beyond the normal, but come to be *giant tadpoles* (Gudernasch ; *Amer. Jour. Anat.*, 1914, xv, 431).

These observations raise the question quite naturally, I think, as to whether a thymus deficiency might not arrest the growth of a child. We have known, of course, for years, at least since 1893, when Ruhräh (*British Medical Journal*, August 29, 1893) reported 18 cases, that in the marasmus of childhood there is an atrophy of the thymus. While now known to be probably a result of the disease and not, as at first thought, the cause, it may presumably be a factor in the production of the old-man facies and contour so often seen. Sajous (*New York Med. Jour.*, ci, 12–585) is sponsor for the theory that *progeria*, a form of precocious old age occurring in childhood, is an expression of *thymic absence*, an hypothesis yet unproven, although one must, from past experience, be wary of scoffing at any of Sajous's suppositions anent the ductless glands.

That children are not analogous to tadpoles is granted, but I will offer you the observation of a very careful man, Kerley, Professor of Pediatrics at the New York Polyclinic (Kerley; Beebe, *Amer. Jour. Med. Sci.*, cxliv, 2–219) had brought to him a boy of 16, who measured 4 feet 8 inches and weighed 76 pounds, and who had not grown in two years. A varied therapy proving unavailing, he was induced by Dr. Beebe, Professor of Experimental Therapeutics at Cornell, whom you will recall as the originator of the serum used in Graves' disease, to use dessicated thymus gland. The result of eighteen months' treatment was an increase of three inches in height and 19 pounds in weight. R. Webb Wilcox reports a growth even greater than this.

The thymus gland is not only an activator of bodily growth, but it can be shown to have an influence upon sexual development. In this case, however, its rôle is that of inhibition. The function of the testes, as you will remember, is twofold ; *resident*, on the one hand, in the cells of Sertoli, the sperm-producing epithelium, and concerned solely with reproduction ; and, on the other hand, *innate* in that portion of the interstitial tissue possessing an internal secretion, the cells of Leydig, which have to do with the development of the secondary sexual characteristics, the masculine habit and psyche. The integrity of one set of these cells is not dependent on the functioning of the other ; for instance, in cryptorchids, where the testes remain undescended,

their small size is due to the maldevelopment of the Sertoli cells, the spermatogenous epithelium, and these individuals suffer no loss of male character although they are sterile. Then, too, in x-ray sterility where the ray is found to exercise a selective influence, sparing the cells of Leydig, while destroying the others, sexual impulse and character, is unchanged. If the vasa deferentia are experimentally ligatured the picture of a cryptorchid is produced; if, however, the spermatic cords are ligated on both sides, a sexual reversion occurs, as in total castration. (Barker; *Am. Jour. Med. Sciences*, cxlix, 1–1.)

The cells of Leydig mature and express their activity at puberty, when the influence of the thymus wanes and atrophy begins. If the thymus be removed before puberty, Stengel (*Prog. Med.*, June, 1914) says that in guinea pigs and rats the testes mature earlier. On the other hand, the thymi of steers are double the size of bulls of the same age. Upon human subjects the surveys of Tandler and Gross are most interesting (Die biologische Grundlagen der secundaren Geschlectscharactere; Berlin, 1913, Vol. I, 169). Among the Scopsi, a religious sect of Russia, self-mutilation is practiced as a ritualistic custom, and autopsies among them revealed in all cases an enlarged thymus. Beyond this there occurs a maldevelopment of the secondary sexual characteristics, or rather an *arrest*, giving rise to a very distinctive type of individuals, a *typus feminus*, or an adiposo-genital dystrophy. These individuals are very plump, and their fat has the regional distribution of the female—about the breasts, the hips, the buttocks, and the mons veneris; an infantile larynx retains the feminine tones of voice; the limbs are long and slender with the genu valgum of the woman. The beard is wanting and the crines sparse, while the genitals are small. Barker has recently developed this habitus as a clinical type, expressive, to use his words, "of an abnormality of the endocrine function of the gonads in the male." Cushing, had, however, already claimed this type of large adiposity with genital dystrophy as a type of hypopituitarism differing from the classical picture of Froelich's adiposo-genital dystrophy in its not being accompanied by undergrowth or infantilism, and suggesting a preliminary activation of the anterior lobe of the pituitary as the cause of the overgrowth.

Froelich's original syndrome was, as you will recall, an infantile type of sexual and skeletal undergrowth, with fatness and a pituitary tumor; the pituitary condition was later more accurately delimited to a deficiency of the posterior lobe. An excellent example of the Cushing type is illustrated in his exhaustive monograph on "The Pituitary Body" (Lippincott, Phila., 1912, page 48) in relation to Case V of his series. A young man, 22, dying apparently from status lymphaticus, presented at autopsy a very large thymus, weighing 30 grams. It is noted in the reports that the cells of Sertoli were present but the interstitial

tissue of the testicle was absent. Since that time Cushing has further intensified this type by a communication published in 1913 (*Am. Jour. Med. Sciences* cxlv, 3–313), covering in Case XXXIV of his old series and adding two new cases studied clinically, and identifying them with the cases reported by Neurath (Fettkinder, *Wien. klin. Wchnschr*, 1911, xxiv, 43).

The point I have in mind to make in this discussion is this: granting that the pituitary be primarily at fault and by its insufficiency permits endocrinous perversions to arise, and granting that absence of the secretion of the cells of Leydig be the direct cause of the agenitalism, there still remains in these cases the evidence of the third gland which, hypertrophied and potent, so dominates the picture as to bring the individual at times to death's door through a maze of its own fashioning, the status lymphaticus. It is more reasonable to assume that the pituitary which stands as a mentor and peacemaker among the warring glands, balancing the tendency to oversecretion of one against the tendency to undersecretion of another, through its inertia permits the potentially powerful to overawe the potentially weaker, with the result that clinically observable evidence of the maladjustment is produced. In this case the normal inhibition of the thymus becomes malignantly strong and enduring and prevents the maturation of the testicular elements in question.

The moral I wish to draw from this is that this easily recognized type represents a thymus *carrier* and inherently bears the tendency to development of a status lymphaticus, with all that that means to the internist and to the surgeon. More properly might we term this the thymic type of adiposity. I may say that Von Haberer, recently (*Med. klin.*, Berlin, x, 25–1045), when about to do a bone resection in a man of 29 conforming to this type, was so impressed by the possibility of a status thymicus and possible untoward reaction to operation, that he did a preliminary thymectomy, finding the largest thymus he had at that time encountered. The anticipated operation was later completed with no ill effects. He states that he believes his to have been the first operation done on the thymus on the basis of the clinical diagnosis alone.

The relation of the thymus to the lymphocyte content of the circulating blood seems adequately proven. Histologists such as Stöhr and Weidenreich believe that the cortex of the thymus is the chief source of the small mononuclear leucocytes, a view supported by the work of Fleming and Prenant. According to Lampe and Liesegang the removal of the thymus in a normal animal is followed by a fall in the lymphocyte count. Pathological investigation, however, furnishes the most convincing evidence of the implication of the thymus in a casual capacity in the mononucleosis of disease. What is known as the Kocher blood-picture, *i. e.*, a leucopenia and eosinophilia with great rela-

tive and absolute increase in the mononuclear elements, was first advanced by that surgeon as a pathognomonic sign of exophthalmic goitre and, when extreme, was considered by many as prophetic of a dismal operative result. Recently Borchardt (*Deutsch. Arch. f. klin. Med.*, 1912, cvl, 182), in an extended study in the medical clinic of Lichtheim at Koenigsberg finds that this picture is not confined to patients suffering from Graves' disease, but is also found in disease of the adrenals and the hypophysis; that these diseases are consistently accompanied by overaction and hypertrophy of the thymus and that, in short, the blood picture is that of status lymphaticus. Resection of the thymus in Graves' disease has immediately been followed by a remarkable transformation in the blood picture. Following Garre's first thymectomy the lymphocytes fell from 40 per cent. to 10 per cent., and Halstead saw a mononucleosis of 38 per cent. reduced to 18 per cent. two days after operation. It is generally agreed now that in any internal gland syndrome, Kocher's blood picture points to activity of the thymus.

There is still another relationship which the thymus bears to the human mechanism, and this is a metabolic one. That it plays a part in the metabolism of calcium and of phosphorus and in the catabolism of nuclein bodies is suspected. The action of the tissue calcium and the condition of the thymus in certain functional complexes arouses one's interest in some strange coincidences. Klose maintains that the cardinal symptom of thymic intoxication is the myasthenia which appears in various diseases in which the thymus is concerned. Now there is one usually fatal disease in which the myasthenia dominates the picture; it is known as the symptom-complex of Erb-Goldflam (Goldflam, *Neurolog Centralbl.*, 1902, xxl, 305), or myasthenia gravis, in which muscular fatigue ensues so rapidly that voluntary movement, such as talking, eating or winking of the eyes, becomes possible for only the briefest pariods. Weigert described in these cases a malignant tumor of the thymus, with metastases of thymus cells in the muscles; since then cases have been described by Claude, Gery and Parak (*Annales de Med.*, Paris, June 1, No. 6, 593), and Roccavilla (*Riforma Medica.*, Naples, xxxl, 14). Hun, Bloomer and Streeter describe also an enlarged thymus and an infiltration of the muscles with thymic cells.

Pemberton and Diller and Rosenbloom (*Am. Jour. Med. Science*, cxlviii, 1–65), in metabolic studies in cases of myasthenia gravis find a marked loss of calcium from the tissues, and one of them naively suggests that perhaps one of the factors in the production of muscular fatigue, the lactic acid, is insufficiently neutralized through the rapid loss of calcium from the body. In this connection is noteworthy the reports of all operators on thymic types of exophthalmic goitre, that the myasthenia which is so prominent a symptom rapidly disappears after thymectomy. The

interrelation of the thymus gland with the other ductless glands is very close and intimate, although the functional effect of such connection is not yet clear. Cushing's autopsy findings in cases of posterior lobe deficiency have but duplicated the results of his earlier extirpation work on puppies, when he found that the hypophysectomized dog retained its thymus. Posterior lobe insufficiency in patients is usually accompanied by a persistent thymus.

In relation to the suprarenal glands a most striking connection is observable. Moreover a most fertile field for conjecture is here opened, if one accepts Kocher's preliminary postulate, as expressed in 1914 at the meeting of the Deutsche Geselschaft für Chirurgie, that in certain cases of Basedow's disease there exists, clinically and pathologically evidence of a complex involving the thymus, the thyroid and the adrenals. The assumption is fair, he thinks, that, given a latent or constitutional hyperplasia of the thymus and a hypoplasia of the adrenals, the onset of the hyperthyroidism may call for a disturbance in compensation. He cites the appearance and disappearance of the pigmentation in Graves' disease, which is synchronous in some cases with the onset and termination of the thyroid symptoms, as confirmatory.

Resultant from animal experimentation and more intensive histological studies of pathological material, a modification is occurring in the long-held theory that Addison's disease is due to destruction of the medulla, or adrenalin-producing portion of the adrenals. In 1899 Biedle (*Innere Sekretion*, 1913, 1 Teil, p. 376), working upon fish, at the zoölogical station in Naples, found that in the skates, in which the adrenal cortex and adrenal medulla are contained in separate and distinct structures, the removal of the cortical portion, the so-called *interrenal tissue*, results regularly in the death of the fish within a period of three weeks, the only symptom being a progressive muscular weakness, the suggestion being that animals *deprived of the entire cortical part* of the gland will not survive, even though the medullary portion remains intact.

Low (*Deutsch. Arch. f. klin. Med.*, 1913, cx, 373) reported in 1913 a carefully-observed case of Addison's disease in which he was impressed by finding at autopsy the complete absence of the specific cellular elements of the cortex of both adrenals and the existence of a well-developed status thymico-lymphaticus. The medullary tissue was intact. The persistently low blood pressure despite the integrity of the adrenalin-producing cells led him to the conjecture whether the thymus was not responsible, inasmuch as Mohr had shown that thymus extracts can produce tachycardia, asthenia and low blood pressure. Incidentally he warns, in view of the frequent status lymphaticus in Addison's disease, against any procedure apt to induce psychic disturbance and a possible lethal result. Kocher's blood picture was present.

Corroboration on mammals of Biedle's work was reported last October in an epochal communication from the Hunterian Laboratory for Experimental Surgery at Johns Hopkins, where Crowe and Wislocki, in extirpation experiments on dogs, were able to demonstrate that the cortical portion alone of the adrenal was essential to life. Complete extirpation of both adrenals was followed as a rule by death within twenty-four hours, accompanied by symptoms of muscular prostration, subnormal temperature, low blood pressure and rapid pulse. Removal (by ligation) of the cortical portion of a fragment of one gland, its medullary fragment being unimpaired, which has sufficed to sustain the animal in apparent good health for six months, was followed by a lethal result in no wise differing from the result of a total extirpation. By ablation of different amounts of tissue they were able to produce varying degrees of adrenal insufficiency covering many months; in many of these cases the most striking feature at autopsy was the picture of a status thymico-lymphaticus, *i. e.*, enlargement of mesenteric and retroperitoneal lymph glands and solitary lymph follicles of intestines and often a hyperplasia of the thymus.

Crowe, moreover, found as a result of a careful search of the records of the Pathological Department of the Johns Hopkins Hospital that in all cases of status-thymico-lymphaticus there was a note to the effect that the adrenals were atrophied, and that in the cases of Addison's disease an enlargement of the thymus was almost invariably recorded. Auld (*Brit. Med. Jour.*, 1899, 1–1327), in partial extirpation of the adrenals in dogs, found great hypertrophy of the thymus in each instance. He interpreted it as a vicarious reaction, for he suggested the feeding of thymus substance in Addison's. Inversely, Wastenson obtained involution of the thymus in consequence of the injection of whole adrenal gland. Barker, of Baltimore, recently suggested giving adrenal extracts to a child with suggested thymic enlargement, where I was in doubt about radiation. Klose has called attention to the danger of complete atrophy of the gland in children after use of x-ray.

In regard to the term status-thymico-lymphaticus, which is nowadays found so often in the literature, this name is applied to a condition found at autopsy where hypertrophy presents in the thymus, spleen, bronchial, mesenteric and retroperitoneal glands and solitary follicles of the intestines. Hedinger (*Verhand. d. Deutsch. Path. Gesellch.*, Dresden, 1907, 29) attempts to divide the condition into a status thymicus and a status lymphaticus on the basis of adrenal changes, but the quantitative implication in the process of the thymus should distinguish the process until further work be done on qualitative changes in that organ. As applying to a clinical condition recognizable antemortem, textbooks leave much to be desired in their picture of the disease, especially as occurring in children.

Thursfield (*Brit. Jour. Child. Dis.*, 1914, xi, 465) takes issue with some commonly-accepted statements, such as death being due to pressure upon the trachea, the great vessels, or the vagus nerve, and concludes that it is a disorder of the endocrinous system. Dyspnoea is given a prominent place in most descriptions, but so-called *thymic asthma* is probably a misinterpretation. Chronic dyspnoea occurs in the thymic tracheo-stenosis of Warthin, but is analogous to trachealstenosis in the adult, *i. e.*, a picture of inspiratory dyspnoea. One textbook gives as illustration an obvious case of spasmophilia. A fatal form of spasmophilia localized in the bronchi, recently reported by Lederer (*Wien. klin. Woch.*, 1913, xxvi, 282), in six patients to which two have been added by Wieland, and termed bronchotetany, further delimits the material, and further study will, I think, narrow the field in children. The picture of bronchotetany is that of an acute expiratory *dyspnoea* attended with intense *cyanosis* in spasmophiliacs, and, on autopsy, areas of atelectasis are found in the area of the bronchial spasm. In adults we have a fairly clear picture of status thymico-lymphaticus as a clinical entity in the so-called "thymus death" occurring in connection with operations, especially about the neck, in persons suffering with Graves' disease. There is cyanosis, dyspnoea, delirium cordis, hyperpyrexia and signs of progressive dilatation of the heart. There is suggested in the process a rapid release of some poison highly toxic to heart muscle. It is believed by European surgeons that Klose has demonstrated such a poison in the substance obtained from the thymi of Basedow patients, with which he produces a similar rapid cardiac decompensation in dogs.

I would like to call your attention, however, in this connection to the character of the death in dogs within twenty-four hours after removal of the adrenal cortex, and to the practical acceptance by many men, including Halstead, of an adrenal insufficiency in exophthalmic goiter of the vagotonic type. Further investigation is needed on the adrenal cortex in goiter deaths. I should say that in children, low blood pressure and myasthenia, in connection with increased mediastinal dulness or widened radiation shadow, might well induce a cautious attitude toward the psychic shock of operation or anaesthesia. In adults, other than goiter cases, the overt expression of a feminine type of adiposity should suggest the consideration of the differential blood count, myasthenic reaction, blood pressure and pulse rate. Even with the assurance of a good pressure and little asthenia, the deep cyanosis and persistent stertor during an operation upon this type is somewhat disconcerting to the clinician.

To me the most vitally interesting thing about the thymus is the attitude assumed toward it in the last two years by those continental surgeons who have most to do with exophthalmic goitre; Garré of Bonn, von Haberer of Innsbruck, the younger

Kocher, Rehn, Klose and others; and in this country reflected in the position of Halstead of Hopkins. Two reports seem to have furnished the incentive for this radical attitude: the report of Capelle, Garré's assistant, in 1911, that autopsy statistics showed a *persistent thymus* in 95 per cent. of goitre cases dying from the severity of the disease or at operation or within twenty-four hours subsequently, and the report of Klose of the presence of a rapidly-acting, highly toxic cardiac *poison* in pathological thymi. It was, at least in the case of Garré, upon this ground that he performed his first primary thymectomy upon a florid type of Graves' disease, and obtained rapid suppression of the tachycardia and a drop in lymphocytes from 40 to 10. Von Haberer reported (*Wien. klin. Woch.*, Jan. 17, 1915) his 24th case, a case already in the preliminary throes of thymic death, unimproved after a unilateral lobectomy and opposite ligation, and which was restored miraculously, it seems, to perfect health. His one fatality was seen when, after subtracting 30 grams of thymic substance, the usual cyanosis, delirium cordis and hyperpyrexia ensued some twelve hours later, and autopsy showed that he had left an enormous remnant of 70 grams. Klose says that Rehn has performed 200 combined thyreothymectomies with no mortality. Halstead, in this country, has been more interested in the results of *deep radiation* upon his own cases which were not improved by former double operations. His results as reported in the Johns Hopkins Bulletin of Feb., 1915, are none the less striking. Improvement has occurred in the following symptoms: *pigmentation*, *exophthalmus*, *tachycardia*, *myasthenia* and in one case *mental symptoms*. The disappearance of the *myasthenia*, which is often so striking a feature, has been the universal observation of the foreign operators, since, as Klose observes, no operation on the *thyroid* alone has ever abolished this phenomenon. The contribution in this instance, of surgery, to clinical medicine, merits profound study by the internist.

The proposition is submitted, Is there a hitherto unrecognized type of thyreo-toxicosis, meriting the appellation of the thymus type and characterized by the following characteristics:

1. A goiter, rather small, rather hard, of long duration. 2. A greyish bronze pigmentation, often diffuse and Addison-like, sometimes patchy. 3. Myasthenia or rapid muscular fatigue which often fills the patient's horizon. 4. Exophthalmos, moderate or wanting, but wide lid-clefts. 5. Tachycardia, moderate except on exertion, but anginoid pains or cardiac discomfort. 6. Emaciation. 7. Gastro-intestinal instability; nausea, vomiting or diarrhea, without assignable cause or previous migraine. 8. Kocher's blood picture positive. 9. Low blood pressure. Halstead thinks there is a picture somewhat like this, the operative risk in which he has unconsciously anticipated in perhaps 20 typical cases among his 500 cases in the last twenty-three years. He

would further be inclined to attribute the so-called "goiter hearts" of colloid strumas to a chronic thymus influence.

The clinical demonstration of an enlarged thymus is a maneuver not entirely closed to argument. However, the following are suggestive responses: 1. Widening of the area of submanubrial dulness on percussion. 2. Boggs finds on neck extension an upward shifting of this dulness. Halstead, by episternal downward pressure has produced a sense of suffocation not normally found. 4. It has seemed to me at times when the patient is instructed to swallow with the neck in extension and the fingers are dipped well down behind the sternum that a rounded mass rises against the hand, which might well be the upper pole.

If the elimination of the thymus in the complex known as exophthalmic goiter permanently presents to the sufferers from this distressing ailment the relief at present claimed, it will record an advance in the therapy of a struma unequaled since the mortality report in 1895 of Theodore Kocher.

Dr. Mallory said that the paper should be helpful to all who had heard it. He had been puzzling about the explanation of the symptoms of a patient now under observation, who had all the symptoms of thymus dystrophy mentioned by Dr. Reede, including the blood picture.

Dr. Williams had reported to the Society a case of adrenal insufficiency which later came to autopsy; the suprarenal bodies were like parchment; the cortex had entirely disappeared but the medullary substance was retained. Death in this case was due to the cortical loss; but what the function of the cortex is is not known. He had seen another case bearing on the paper; a man had been apparently cured of myasthenia gravis by the administration of thymus substance. This should be so when we remember that myasthenia is a symptom of thymus dystrophy. We must remember that many of the symptoms in these disorders may be secondary; that status thymico-lymphaticus may primarily be at fault; or some infection, or a central nervous disorder. He regarded the paper as by far the best presented this year.

Dr. P. B. Johnson gave a brief report of a case of sudden death in a girl; the autopsy revealed no cause except some congestion of the brain and enlargement of the thymus. The patient was a thin, nervous girl who came in with a burn of the foot. She developed numbness of the arm and face, then choreiform movements, delirium, and later died.

Dr. Simpson said that the association of thyroid and thymic disorders had been recognized for some time in this country. Death following thyroidectomy in cases in which the thymus was found enlarged, led to preliminary x-ray examination, and if the thymus was found enlarged, to preliminary x-ray treatment; since these precautions have been adopted there have been no

more such deaths. Status lymphaticus is frequently treated by pediatricians by x-ray with good results. He had studied his own cases of hyperthyroidism with radiographs and had found no instance of thymic enlargement. There are probably cases with and without thymic involvement; when the thymus is involved there will be no improvement unless the thymus is also treated. Why will the use of thymic substance help cases of hyperthyroidism if the symptoms are due to thymic intoxication?

Dr. Roy rose to thank Dr. Reede for the most charming paper presented this season. The literature of this subject as well as that of many others is so voluminous and so chaotic that the more we read the more confused we often become; well digested and orderly papers like Dr. Reede's will always be immensely helpful.

Dr. R. S. Lamb wished also to thank Dr. Reede for the paper. Dr. Lamb had referred cases of exophthalmos to Dr. Reede who studies the patients just as thoroughly as he had prepared this paper. In some of these cases Dr. Groover had given treatment according to the Halstead method with marvelous results.

Dr. Reede said that the experiments on the adrenals had to do with the elimination of function of part of the glands, not extirpation. As to the influence of infections on the production of disorders of the ductless glands, we will probably find more and more evidence that infections are at the bottom of these obscure derangements. Dr. Johnson's case in a way suggests an instance of thymic death; Dr. Reede was sorry the surgeons had not spoken of such cases. As regards x-ray treatment of the thymus, Kocher subjects this gland to irradiation before the combined operation. X-ray treatment, according to Kocher, does not give permanent help. As to giving thymus substance in some cases of thymic hypertrophy, the result may be somewhat like that observed in cases of hypertrophied thyroid in which thyroid substance is given; the symptoms improve but the patient gets worse.

THE RELATION OF THE PHYSICIAN TO THE CORONER'S OFFICE.*

By Charles S. White, M. D.,

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The powers and duties of the coroner are little understood by the physician or laity, but are far more important than is generally known, and deserve much greater attention than is devoted to them.

The office is of early origin and was closely associated with

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public justice, but it has been restricted in the modern era to concerning itself chiefly with the investigation of deaths which have occurred as the result of other than natural causes. At one time the duties of coroner included the apprehension of criminals, maintaining order in court, indeed, those largely of sheriff or bailiff, and some of these powers remain and are in force at this writing and will be mentioned later.

It is perhaps the popular conception that the word "coroner" is a distortion of the word "crowner," meaning an officer of the crown, but as such offices were numerous, this can hardly be the true derivation. The word had its origin during the Saxon times in England, when public justice was dispensed in the open, an improvised court being installed by the assembly gathering within a circle of rough stones or earthen ramparts. Here the plaintiffs, defendants, witnesses and audience collected and the multitude was known as the "corona populi." At times the hearings became turbulent and the officer whose duty it was to preserve order was known as the coroner. Many of these hearings were concerned with the sudden or violent death of a citizen, and the coroner's duties were to inquire into such death and apprehend the guilty. Gradually, his duties narrowed down to the inquiry necessitated by a death, still maintaining few of his powers as sheriff, till at the present day the duties are much the same as at the close of the fourteenth century.

The inquiry conducted in public by the coroner into the cause of death is known as the inquest. It is not valid unless the body is viewed by the coroner and a jury of six men. In the conduct of the inquiry his work is largely judicial, and he is bound to inquire into all facts of circumstance and person whereby death has been caused, but does not extend his investigation to accessories after the fact. As soon as practicable after notice of death due to unnatural cause, he shall view the body with reference to violence, casualty, etc., and summon a jury of six. No exceptions or challenges are permissible to the persons of the jurors and it behooves the coroner to be circumspect in the choice of his panel. In the capacity of judge of his court (and the coroner's court is a court of record) his duties are so distinctly judicial that he is protected under the principles which protect judicial officers from responsibility in civil action brought by a private concern or person. The testimony of witnesses is taken in writing and should be *verbatim ;* the words of the witness should be his own and not put in his mouth by coroner or counsel. The record is of the same character and importance as any other court record and can be made the basis of an impeachment of any or all witnesses' testimony in a subsequent trial.

The object of an inquest is to ascertain the cause of death, whether of violent or criminal agency. The authority for holding an inquest is necessarily judicial, but how is the coroner guided

in exercising his jurisdiction in a certain case? Quoting Vicker's on *the duties of the coroner*, "There is not nor could there be in the nature of things, any classification of circumstances by law prescribing his action or fixing precisely the limits of his authority. * * * When called upon to act, he will decline or proceed to the investigation accordingly as the circumstances of the particular case are or are not of suspicious character as to render proper an official examination, and of these he is the sole judge. The coroner is not required to report to any official or body of officials in the county any reason why he acted or declined to act. He is not bound to make any statement as to the propriety of an inquest in any case." It is not necessary that an inquest be held at the place the body was viewed, and one inquisition may be taken on the bodies of several persons who have been killed by the same cause or died at the same time.

To obstruct a coroner or jury in his view or inquiry is a misdemeanor, and a refusal to permit the coroner to enter a house may be punished because it is a hindrance to the exercise of legal authority. If a body has been buried before the inquest, the coroner may have it disinterred if the burial has been recent; if long interred, an order from the circuit court is proper if not necessary. If the condition of the body is such that no facts can be ascertained by viewing or autopsy, then the inquest should be conducted by a justice without viewing the remains. All facts which tend to implicate parties before the death need to be inquired into, and the scope of such an examination is at the discretion of the coroner. Collateral facts may be inquired into, such as signs of insanity in the deceased, whether deceased was obnoxious to any combinations of persons or society, fraternity or union. The suspicious death of a person in custody, upon ships or Government reservations is within the compass of the coroner's office, for no jurisdiction is exempt from his supervision in respect to location.

Failure to attend, refusal to act, or misconduct on the part of a juror subjects him to a fine on complaint of the coroner before a justice of the peace. The coroner is the only person entitled to pass upon the propriety as to the persons admitted to an inquest, and he may exclude those whom he wishes without subjecting himself to liability.

It is indictable to bury a man who dies a violent death before the coroner or his jury has sat upon him. The coroner may compel the attendance of any one whose testimony may be requisite in proving any fact or circumstance relating to the inquest, but whether he can punish for non-attendance or contempt of court has not been clearly defined and never tested in this District.

As it is plainly the coroner's duty to elicit all material facts leading up to and bearing upon the death, in an unbiased manner, counsel are not needed, and when present can take no part in the

proceedings except on behalf of the person directly accused of crime.

A coroner's inquest is a judicial proceeding, a grand jury investigation is not, and the depositions before a grand jury are not evidence against a prisoner in case of death of the witnesses; those taken before the coroner are evidence because cross examination is permissible.

When the coroner is informed that a dead body is found within his zone, he should note the name and address of the person supplying the information and proceed to take steps to investigate, usually first visiting the scene and viewing the body, which then automatically is in custody of the coroner, and can be prepared or transferred at his discretion.

The code of the District of Columbia states: Whenever the marshal is a party to any cause or interested therein, or it is unfit on other grounds that he should serve and execute the process to be issued therein, such process shall be issued by the coroner, and he shall be paid the same fees and compensation for serving and executing the same which would be payable to the marshal in similar cases, and shall account therefore to the Treasury of the United States.

The above presents in a fragmentary manner the powers and duties of the coroner without details regarding the verdict, drawing up of documents of commitment, bail and matters of more or less routine and clerical nature. We shall now consider the contact of the physician as such with the office of coroner.

In what instance does a death become a coroner's case? This question has perplexed every physician at some time and we are often at a loss for a correct answer. It has been the experience of nearly every one in active practice to furnish a certificate of death which was not acceptable to the health office on the ground that only the coroner could issue it. In the premises it may be stated that a physician who examines a body only after death, no ante-mortem examination having been made, cannot properly issue a certificate, as the usual form states specifically "That I hereby certify that I attended the deceased professionally during —— last illness," consequently a postmortem visit removes all eligibility as a signer of such an instrument. It may be noted that the certificate states "last illness," so that attendance at a long period before death very properly may be questioned as an interpretation of "last illness." How shortly before death, provided but a single visit is made, may qualify a physician to return a certificate? There is no time fixed by law, although it is understood that the time is specified in some States. Should the physician's initial visit be but a brief period before the death of his patient, it is perfectly proper for the physician to issue the certificate if the death were undoubtedly due to natural causes, such as carcinoma, apoplexy, etc.

Should there be any question as to the nature of the malady or should there be a suspicion of suicide, accident or homicide, then the case is one for the coroner's office.

Let us assume, on the other hand, that the deceased had medical attention from his physician for a long period, suffering from pulmonary tuberculosis or chronic endocarditis. It is very probable that the physician visits his patient only at long intervals and possibly death occurs two weeks from the last visit of his doctor. In case of death who shall sign the certificate? There is rather an elastic usage covering such cases and no definite period is prescribed within which the physician must see the patient in order that he may properly state that the physician attended him in his last illness. We must have recourse to the word "reasonable," and state the physician should have attended the deceased within a reasonable period, so far as it can apply to visiting the sick.

The coroner does not investigate those cases known to be due to natural causes if the deceased had medical care during his last illness, but here again the definition of natural causes needs illumination. Natural causes include pathological conditions produced within the body and not dependent upon internal or external gross violence. We cannot erect a partition between the natural causes and violent means, as in some instances they merge one into another, such as ptomaine poisoning, chronic poisoning in some of the trades. All deaths due to accidental or violent means, and this includes poison self administered, can be certified to only by the coroner, unless the violence occurred more than a year and a day prior to the death. In the case of homicide when the violence was inflicted more than three hundred and sixty-six days prior to death, a statement of this fact should be noted on the certificate by the attending physician and the matter brought to the attention of the prosecuting attorney of the District.

When accident or violence is the remote exciting cause and death ensues some months later, the real cause is often overlooked by the physician and he fails to report it as a coroner's case. As an example, a person may fall on the ice, fracture the femur, develop bed sores and in the course of a few months die of exhaustion. This is a case for the coroner, as the cause of death primarily was violence. The office of vital statistics, as it is termed in some localities, or the Health Department, as it is known here, may refuse to accept a certificate of death when the primary cause is violence, and the coroner is called upon to reissue or endorse such a certificate after viewing the remains and sifting the circumstances, with or without an inquest, as he deems best.

Only a year or two ago an elderly woman was injured about the head in a street railway accident and died ten months later of cerebral softening, secondary to the injury to the head, ac-

cording to the certificate issued by the family physician. The Health Department maintained that only the coroner could issue the certificate. The family doctor issued a new certificate when this phase was brought to his notice, and the new certificate eliminated the coroner because the physician omitted in certificate number two any mention of an accident, differing from the first certificate in this particular. About a year later the railway company was sued and the attending physician made a deposition to the effect that in his opinion the accident was the cause of death. It is difficult to understand why the accident was not a factor in the Health Office record, but was the primary cause of death in the court record, and prompts the thought that an autopsy would have been inimical to the interest of the plaintiff.

What is the physician's duty when he is confronted with a coroner's case? He should immediately notify a police officer or the station in the precinct in which the death occurred and leave further inquiry to others. His accountability ends here. It is not even necessary for him to notify the coroner at 3 A. M., that such and such a person was found dead in bed. The police have instructions to take cognizance of the appearance of the body, room, exits, fixtures and other conditions, which may have a bearing on the cause of death, and in addition, examine the inmates of the house regarding the habits of the deceased, when last seen, etc., so that a rather complete report is made to the station and police headquarters, and this in turn is transmitted to the coroner with the least possible delay.

Should the case when seen by the physician, although life be extinct, suggest homicide, it is not outside of his province to make a mental or written memorandum of any fact or condition which may be manifest, without investigating the circumstances, for use at an inquest or trial. Should the patient be in a dying condition as the result of a wound inflicted by himself or another, the physician should concern himself only with the welfare of the patient and render all aid possible to prolong or save life. The police should assume charge of the effects of the injured or deceased, and when homicide is suspected, remain at the place and detain witnesses until relieved by some one in higher authority. Valuable evidence may be destroyed by the eager efforts of self-appointed sleuths. Weapons and other articles which may be introduced in a hearing should be turned over to the police.

It is not unusual for a physician to be called to some public place to give first aid, only to find a corpse. When a natural cause of death is apparent, such as pulmonary hemorrhage, it is not only permissible but desirable that the body be removed from the morbid gaze of the public and the coroner's office will not object. It is a misconception of the law to believe that the body must remain where it was overtaken by death. We do not believe there is any excuse to ransack the pockets for identification,

as it sometimes happens that the friends of the deceased make the claim that sums of money or jewelry have been removed from the body of the deceased. The identification and care of valuables is a police matter.

Criminal abortions and self-induced abortions resulting in death are properly referred to the coroner for scrutiny and should be reported to the station house. It is not uncommon for the coroner to be notified by a physician that the physician has under his care septicemia following criminal abortion and that death seems inevitable. A moment's reflection will certainly make it plain that a coroner is never in a case officially until after death, and in the case just cited the attorney for the District (United States Attorney in the District of Columbia) should be notified, so that proper steps may be taken to secure an ante-mortem statement and collateral facts. Most ante-mortem statements presented to the coroner's jury, unless obtained under the direction of an attorney, are useless in a criminal court becuse of a technical error, and many a rascal escapes a well deserved penitentiary sentence through the inadmissibility of such evidence.

Many cases of suicide present difficulties for the coroner. The physician who is first called in attendance often obtains information that is denied the coroner; for in the excitement of attempted poisoning, the family may speak freely to the physician who is first upon the scene, but after the death of the individual and calm reflection of the relatives, it is not rare to find the family as loquacious as the proverbial clam, and there are reasons. There is a certain stigma to suicide that every one shrinks from, and it is only a human trait to conceal the weaknesses of the dead. Certain religious rites are denied suicides. And, lastly, a clause in many insurance policies excludes the beneficiary in case of suicide. This is perhaps the chief reason for secrecy concerning the details of death, but it can be stated that the so-called suicide clause is not worth the space it occupies unless it can be shown that self-destruction was premeditated and executed for the purpose of gain. The public is not aware of this, and the insurance companies do not enlighten it. The physician can supply the coroner with very useful data. The coroner may have all manner of influence brought to bear upon him to issue a verdict of accidental death, and when reasonable doubt exists, the deceased is given the benefit of it; but because the certificate states "suicide" in cases that merit it, the office has come in for abuse and invective and the coroner is unpopular—not that he is ever particularly popular; the office precludes such a state. In two cases of suicide which came under the coroner's notice, in one the claim was made that the drug was taken as a cough medicine and in the other it was stated that suicide was impossible, although in each instance about an ounce of pure carbolic acid was swallowed from a small-necked bottle. Only two accidental deaths from phenol have occurred in

this district in the past fifteen years. The coroner can hold an inquest in any case to determine if death was suicidal or accidental, and may order an autopsy without an inquest to learn the cause of death.

A post mortem examination is desirable in every suspicious fatality, especially so when the clinical manifestations have been meager or complex; but the spirit of economy which actuates the appropriation committee of Congress does not permit of such an expenditure of funds, for each autopsy costs the District at least ten dollars, and an inquest forty dollars or more. Much pathological data are buried with the cadaver that never come under a microscope, and it is a source of much regret to the coroner's office that an autopsy cannot be held in certain cases that are of unusual interest to a hospital staff. Quite often the hospital is more than willing to have the autopsy done without cost to the District if authorized by the coroner, but this cannot be permitted because all necropsies ordered by the coroner must be performed by the deputy coroner in his official capacity and made a part of the record of the office. The coroner cannot delegate this power to anyone. In other words, the District cannot accept services because they are gratuitous any more than one could voluntarily pave the sidewalk in front of his residence. The hospital internes sometimes get permission to do an autopsy by, figuratively speaking, holding a club over the relatives or friends of the deceased, in the shape of a description of the horrors of the morgue and inquest, and rather than subject the body to such so-called publicity and desecration, permission is granted. This practice is not condoned by the coroner, and in justice to the morgue it may be said that the facilities for caring for the dead surpass those of nearly every hospital in this city.

There have been instances where the certificate of death has been withheld by the attending physician until his bill has been paid. When such cases are reported to the coroner's office vigorous steps are taken to remedy this reprehensible practice.

It is unlawful to cremate or otherwise destroy any body or part of a body unless the burial permit is countersigned by the coroner, and it is likewise improper for a physician to sign a certificate of death, no matter how long he has been in attendance, when the identity of the deceased is unknown.

If prescription writing is a lost art, as someone has said, then the writing of death certificates as an art has never been discovered, if one may judge by the many which are entered at the Health Office and referred to the coroner for endorsement or investigation. As an example of what the coroner has to contend with, we append a few extracts from certificates which have been submitted to him for revision:

A. Cause of death. Primary, "Christian Science." Immediate, "Fractured leg."

B. Cause of death. "Lamp turned low at night."
C. Cause of death. "Palpitation of heart."
D. Cause of death. "Bitten to death by bed bugs."

In many municipalities the office of *coroner* has been abolished and in its stead the office of *examiner* has been created, thus dispensing with the coroner's jury. There is much to be said in favor of this system, but this is not within the scope of this paper.

It is not out of place, however, to mention that the salary of the coroner of the District of Columbia is exactly the same today that it was in 1874, despite the fact that the population of the city has grown tremendously in the past forty-one years. In 1874 the coroner's cases numbered 194, while this year the total will be approximately 1,750, an increase of over 800 per cent.

That the coroner's office requires a person of experience, with an unlimited amount of tact and patience, to say nothing of a judicial temperament, must be apparent, and the author believes that the District has this office in competent hands.

Dr. Woodward said that the subject had been well covered. The profession will best understand the relation of this office to the physician by realizing that the Coroner may not be a doctor at all. The appointment of a layman to this office in this city was not long ago nearly an accomplished fact, but it was halted by pointing out the additional cost of administering the office if the Coroner could not sign death certificates. The Coroner, however, not only needs to consider the physiological and pathological facts in regard to deaths coming to his official knowledge, but he must consider also the time, place and attendant circumstances to determine their possible relations to crime, etc. The attending physician cannot do this because he does not possess the legal knowledge necessary to analyze such cases. The Coroner of Cook County, Illinois, realizes the full possibilities of the office and uses it not only to determine whether crime is involved in sudden and violent deaths, but to study the causes leading to accidental deaths and biennially publishes a report bearing on these studies, thus contributing to safety-first movements and the like.

Physicians who are called upon for aid in cases of violent death may enable the family to avoid difficulty and publicity by communicating directly with the Coroner ; no inquest is necessary unless suspicious circumstances surround the case.

It is well to have such papers as Dr. White's occasionally to show just why the Coroner's office is necessary. The statements in the paper bearing on the inadequate salary of the Coroner's office are heartily endorsed.

Dr. W. B. Carr emphasized the importance of the Coroner's office from the standpoint of vital statistics and the legal aspect.

It is at least one office in the District which is able to save much expense by avoiding unnecessary inquests.

Dr. Chappell asked if a physician is barred from signing the death certificate in cases of sudden death occurring in a family long attended by him when he has not been in recent attendance upon the deceased ?

Dr. G. Wythe Cook said that one reason for the actual viewing of a body by a Coroner's jury is to determine the identity of the corpse as that upon which they are deciding the circumstances of death. He inquired if it is true that the Coroner should pass upon the issuance of the death certificate in cases in which death is a remote sequence of an accident, as for example after fracture of the hip in the aged.

Dr. E. L. Morgan called attention to certain curious folk customs among primitive people having to do with means of determining the cause of death.

Dr. Reichelderfer inquired as to the bearing of the law upon the disposition of pathological specimens in hospitals; whether the authorities should give official permits for the disposition of amputated limbs, etc.

Dr. White said that under the law parts of bodies may not be disposed of without the Coroner's sanction. Death following an accident, if bearing any relation whatever to it, when occurring within the same year as the accident, calls for an inquiry by the Coroner. Physicians attending a patient at long intervals for an illness may sign the death certificate if the death was due to the same illness, but not otherwise.

CASE OF HYDATID CYST OF LIVER—OPERATION, RECOVERY.*

By George Tully Vaughan, M. D.,

Washington, D. C.

The opportunity of operating on the patient was due to the courtesy of Dr. John Constas. J. A. S., age 22, native of Greece, waiter, came to the United States in 1913; had lived some time in Constantinople. Shortly before coming to the United States, had gastric pain for several days; subsequently had several similar seizures, lasting one to three days, but without vomiting or chill or fever. In February, 1915, in West Virginia, had another seizure and was sent to hospital. Later came to Georgetown University Hospital, this city. Temperature 98, pulse 76, marked epigastric fulness, feeling of resistance to pressure, and slight tenderness. Suspected syphilitic liver, dropsy of gallbladder, or

* Reported to the Medical Society, May 19, 1915.

hydatid or other cyst of liver. March 15 Dr. Vaughan made incision in median line of abdomen, over the most prominent place, found cyst in left lobe of liver, containing 500 c.c. of clear fluid; it was aspirated, the lining membrane withdrawn, edges of cavity stitched to abdominal wall, and gauze drain introduced. Healing uninterrupted; patient discharged recovered in three weeks. Typical scolices and hooklets of the hydatid were discovered in the fluid of the cyst.

Dr. Constas said that this young man was a resident of Wheeling, W. Va.; he had suffered for three years from periodical abdominal pain. He had been examined by a number of physicians who had been unable to make a diagnosis. His treatment had been largely dietetic but this had given no relief. Dr. Constas' examination had resulted in discovering nothing except some bulging in the gallbladder region; there were no other symptoms except weakness and occasional pain. There were no gastric symptoms, and careful examination by Dr. Verbrycke discovered no sign of trouble in the stomach or intestine. The substitution of a liberal diet for the scanty one formerly allowed was followed by improvement. After the operation the man made an uneventful recovery, gained much in weight, and is now quite well. The case was of unusual interest to Dr. Constas because it was the first case of the kind which had come to his notice.

Dr. Verbrycke said that Dr. Constas must have forgotten the details of his report on this case. Dr. Verbrycke had found certain evidences of trouble and had made a diagnosis of duodenal ulcer and a cyst, either echinococcus cyst of the liver or hydrops of gallbladder from kinked cystic duct. His diagnosis had therefore been 50 per cent. correct. He was not yet convinced that the man did not have duodenal ulcer also; there was modified hunger pain, induced by smell of food; there was occult blood in the stools, and in duodenal contents; there was gastric hypersecretion and hyperchlorhydria; there was 4.5 per cent. eosinophilia. At his examination he had found a globular mass extending from the gallbladder region downward and to the left. He had considered syphilis of liver, sarcoma, hydrops of bladder, etc., as explanations; a negative Wassermann ruled out syphilis, and the x-ray picture was negative, which negatived both syphilis and sarcoma; gas distention of stomach showed that there was no retrogastric tumor. Dr. Vaughan had not spoken of the distinct adhesions running from the duodenum to the gallbladder. While palpation of the duodenum did not reveal ulcer, Dr. Verbrycke was inclined to believe that it was present, nevertheless, from consideration of the other symptoms.

Dr. Constas said that Dr. Verbrycke had suggested the various diagnoses just enumerated and the result of the operation indicates how nearly an exact diagnosis can be arrived at by careful clinical means.

Dr. Williams was surprised to hear Dr. Verbrycke say that syphilis could be ruled out because the Wassermann reaction was absent; Dr. Williams rose to refute that statement because it is not a sufficient criterion of the absence of syphilis.

Dr. Vaughan could not be sure there was no duodenal ulcer, but it seemed most likely that there was none because the man got entirely well with no treatment of the duodenum. He had made up his mind that the tumor was in the left lobe of the liver; moreover, it was situated exactly in the median line and he had seen eight or ten cases of liver gumma situated in just that spot; therefore, he had considered that diagnosis as a likely one.

CASE OF FIBROSARCOMA OF THE ORBIT, SEVENTEEN MONTHS AFTER EXENTERATION AND X-RAY TREATMENT.*

By Robert Scott Lamb, M. D., F. A. C. S.,

Washington, D. C.

From time to time all of us meet with cases which seem hopeless or inoperable and in our best judgment there is no probability of successful treatment. Perhaps the old saying that "Where there is life there is hope" is very indelibly impressed upon us by such cases as the following:

R. S., female, colored, aged 39, housewife, had been visiting the clinic at Freedmen's Hospital for some time for pain and exophthalmos of the left eye. Eighteen months before, the patient had noticed pain and beginning swelling. The pain had been controlled for a while, but eventually, it became so severe and sight was useless (she had large objects and very poor projection) that it was decided to remove the eye which was causing the pain and possibly remove the tumor which lay behind the eyeball, and in our estimation was undoubtedly the cause of the secondary Glaucoma; therefore the patient was admitted to the hospital Sept. 11, 1913. After complete examination of the general system I decided to operate, and did operate, Sept. 19, removing the eye. Behind the eyeball was found a mass filling the posterior half of the orbit, including the apex and apparently attached to the periosteum. To digital examination it felt as does the cervix uteri or the tip of the nose, slightly depressed at center. In view of the fact that there had been an innominate aneurism, with mitral insufficiency, and there had been objection on the part of the anaesthetist to giving the anaesthetic in such a case, and the possibility of an exenteration taking considerable time, I decided to abandon the operation at this point. My idea was that per-

* Reported to the Medical Society May 26, 1915. For discussion, see page 255.

haps the bone was involved ; that it was probably a hopeless condition, and that any operation would, of necessity, be so extensive that it would hardly be advisable ; besides which consent would have to be obtained from the woman and her husband before proceeding with any further operation.

The patient got on very well following the operation, but the tumor began to grow and finally extruded from the orbit and became painful ; it was then decided, at the end of several months, that the x-ray had been in use, that as the tumor had softened somewhat, and yet had increased in size, it was to the best interest of the patient to do a complete exenteration of the orbit. She was, therefore, readmitted to the hospital and the second operation was done Jan. 25, 1914.

An exenteration was done, almost complete, that is complete, except for the very tip of the apex of the orbit in the neighborhood of the optic foramen ; this portion was cauterized deeply, practically to the foramen, at three or four places, thereby shriveling the bleeding mass. The wound behind it healed very well, except for a slight suppuration which ceased as soon as the x-ray treatment was resumed. I call attention especially to this in view of the surprise it gave me to see the wound, the dressings of which had been saturated with discharge, dry out so quickly and heal thoroughly from the bottom to the surface, closing over in a very short time. The patient has been quite well since then and the other eye has never been affected. Of course the length of time is not great, but a year and a half of comfort and health, free from worry and anxiety, has been a great benefit to the patient. The pathologic laboratory report was fibrosarcoma. There is no sign of recurrence.

Another case of mine which had been diagnosed and refused operation because of its being an osteosarcoma, turned out to be a blood cyst of the orbit. This case I reported elsewhere.

I wish to express my thanks to Dr. C. Augustus Simpson who so kindly carried out the x-ray treatment in this case.

CASE OF MALIGNANT EPITHELIOMA TREATED BY ONE MASSIVE DOSE OF X-RAY.*

By C. Augustus Simpson, M. D.,

Washington, D. C.

In connection with the very interesting case presented by Dr. Lamb, which shows the excellent result following the removal of the eye, and the giving of massive doses of x-ray to the wound, I would like to present a case of malignant epithelioma of the forehead that has had one massive dose of x-ray.

* Reported with patient to the Medical Society May 26, 1915.

S. S., 50 years old, resident of the District, noticed a growth on her forehead seven years ago, which slowly increased in size, finally ulcerating, and at times bleeding slightly. She was seen by several physicians at various times, who advised her of its danger. Four years ago she had the Roentgen ray applied. She claims that she was exposed to the ray every second day for several weeks. At the end of this time the bleeding and ulcerating points had somewhat improved, but the tumor was increasing in size; there had been no irritation from the x-ray. Following these incomplete results she was told by the same physician that the ray would be useless in the future, and was advised to have the tumor removed by caustic or a surgical operation. In March, 1915, she consulted me, at the suggestion of Dr. Kimball of this city. At this time she had an extensive fungating, ulcerating tumor on the forehead that measured three inches in length, two inches in width, and projected above the surrounding normal skin fully one-half inch; the size outlined by pencil marks. The lesion was in places covered with crusts and particles of dried blood, while the surface was irregular, vegetating, intensely red and bordered by an elevated, hard, pearly, cartilaginous-like border, over which coursed dilated bloodvessels. She gave a history of a continuous growth of the tumor during the past seven years. All combined made the clinical diagnosis of rodent ulcer justifiable and certain. In March she was given one massive dose of x-ray consisting of six points, Hampson's radiometer. This large dose was divided so that I gave one-half of it, three points, in the morning and the same quantity the afternoon of the same day. The ray was given through 2 mm. of aluminum, the distance of the tube from the patient being 5½ inches. An ordinary x-ray tube and a 1-kw. transformer with a four-inch spark gap were used as I had not at this time begun working with the Coolidge tube and the 16-inch coil that I now employ.

At the present time, as you will see, all that remains of the old fungating tumor is a hard, nodular lesion, the size of a small bean. This I am satisfied will be removed by the next massive dose of x-ray. I do not present this as a cured case, but to demonstrate to the Society the effect that one massive filtered dose of x-ray has produced in a patient who had been unsuccessfully treated by the older fractional dose method of giving Roentgen ray. It is needless to say that such massive doses, to be given with the necessary accuracy, must be regulated and dosed by the Sabouraud pastilles or the Kienbock strips.

Dr. Williams was particularly interested because several years ago he had tried to have such work done in another kind of cases, because experiments abroad had indicated the possibility of influencing deep structures with properly filtered rays. He had sought to obtain such treatment for hyperplastic thyroids, but

had been unable to obtain it; such work as was done was by fractional doses of soft rays, which did no good. Now with the Coolidge tube we may be able to do better even in the treatment of very deep structures. He had some time ago reported to the Society a case with pituitary tumor; this patient had been much helped by x-ray treatment. Failures in the past had been due to defective technic and should not give rise to pessimism as to the possibilities in the use of the rays themselves.

Dr. Roy said that about six months ago he had sent a patient to Dr. Simpson for treatment by x-ray for hyperthyroidism. This patient had been treated by a number of the best men in the city with no relief. She had constant fever and was rapidly losing ground. After six treatments the fever disappeared, the pulse fell from 120 to 80, and she gained fifteen pounds in weight.

Dr. H. H. Hazen said that all x-ray men have had the experience of seeing apparently incurable skin cancers get well under x-ray therapy. But it must be remembered that there are two kinds of epithelioma; the basal-cell variety gets well and does not metastasize; the prickle-cell variety does give rise to metastasis, and in such cases the glands should be excised.

Dr. R. S. Lamb said that whether by accident or design we seem to have hit upon a very helpful method of treatment, viz. x-ray treatment both before and after operation. The preliminary treatment takes the load off the circulation in advance and allows a better chance for recovery.

Dr. Simpson felt satisfied that cases of exophthalmic goiter can be helped provided the right dose is used. The exophthalmos is not improved, but the pulse, tremor and goiter are all helped. The thymus gland is very easily influenced by the rays, as easily as the ovary and testicle, and if the two glands must be treated together for the relief of Graves' disease, as seems likely, then the use of the x-ray is logical. As regards the treatment of basal-cell epithelioma, Pfahler says that 100 per cent of such cases can be cured by x-ray treatment. As regards the prickle-cell form, the last thing a radiographer would do would be to remove a section to prove the variety; but this form is also curable by proper x-ray therapy. The pastille dose is the proper dose of x-rays; he himself was the first man in this country (1912) to advocate the use of this means of measuring the dose.

Obvious Reason. — She — "Sometimes you appear really manly, and sometimes you are effeminate. How do you account for it?"

He—"I suppose it is hereditary. Half of my ancestors were men and the other half women!"—*Tit-Bits.*

DR. JOSEPH TABER JOHNSON.

JOSEPH TABER JOHNSON, M. D., A. M., Ph. D., LL. D., an honorable member of this Society has been practicing medicine in this city for fifty years, during which time he has faithfully served the Society as President, Censor, member of important committees, and in many other capacities, and is now the tenth in order of seniority. He has maintained the honor, dignity, rights and interests of the medical profession. As professor of Obstetrics and Gynecology since 1868, he received the highest honor at home and abroad; his alma mater, Georgetown University, in 1914 conferring upon him the honorable degree of doctor of laws for distinguished work as an author, a teacher, an obstetrician, a gynecologist and an abdominal surgeon. His straightforward and honorable career has endeared him to his college, his hospital colleagues, and his pupils and his many patients.

Therefore be it

Resolved, That this Society takes pleasure and pride in calling the attention of its members to such a notable example of a career passed in the honorable and conscientious performance of the duties of life.

Resolved, That this Society expresses the hope that many years of health and happiness are in reserve for our esteemed colleague, to whom our best wishes are cordially extended.*

CHERRYDALE, VA., *May 24, 1915.*

DRS. S. S. ADAMS, GEO. M. KOBER, G. WYTHE COOK:

My dear doctors: Your very kind letter of the 22d instant, stating that you had been appointed a committee by the Medical Society of the District of Columbia, to arrange a dinner complimentary to me (on account of the fact that I had passed the fiftieth mile stone in the arduous work of our profession) at such a time as would suit my convenience, has been received.

In reply I beg to say that I appreciate from the depth of my heart this expression of kindly fraternal spirit from yourselves, and also from the Medical Society, as stated in their preamble and resolution of congratulation, and that while the month of June would be the most appropriate time for the dinner, as the fiftieth anniversary of my graduation in medicine, and seventieth of my birth, both occurring in that month, still, on account of the approaching hot weather and the probable absence from the city of many of our friends, the occasion had perhaps better be postponed until some evening in the early part of October.

Thanking you again, gentlemen of the committee, and through you, the members of the Medical Society.

I am gratefully and fraternally yours,

JOSEPH TABER JOHNSON, M. D.

* The above preamble and resolutious were presented to the Society by a committee consisting of Drs. S. S. Adams, G. Wythe Cook and G. M. Kober, and were unanimously adopted at the meeting May 19, 1915.

In Memoriam.

DR. GEORGE NELSON PERRY.

Dr. George Nelson Perry was born at Layman, Ohio, Oct. 12, 1850. He attended the public schools, and afterwards the Bartlett Academy at Bartlett, Ohio, and Mount Union College at Alliance, Ohio. He came to Washington and for some time was bookkeeper with the firm of Luttrell and Wine. He then entered the U. S. Signal Service and served therein until 1892. He graduated in medicine at Howard Medical School in 1884, after which he practiced medicine in this city until a few months before his death, May 10, 1915. He was elected an Associate Member of the Medical Association of this District Oct. 5, 1886, and became a full member April 5, 1892; was elected a member of this Society April 4, 1894. He was first married to a Miss Took, in Ohio; she died; and he was married a second time to Miss Mary E. Brown, of this city, in 1880. She survives him.

Dr. Perry's great great grandfather, Thomas Perry, served in the War of the American Revolution, and his great grandfather, John Perry, in the War of 1812.

From the time of his graduation in medicine Dr. Perry served as an instructor in the Howard Medical School, as Demonstrator of Anatomy from March 25, 1884, to April 22, 1892, and in addition was Lecturer on Gynecology from Sept. 23, 1890, to April 23, 1891. Was attending physician in the Dispensary of Freedmen's Hospital from 1894 to 1900; Lecturer on Diseases of Children from April 13, 1894; and Professor of Pediatrics April 30, 1895, until April 29, 1899. Was also Professor of Diseases of Nervous System from May 6, 1899, to June, 1904, and Professor of Nursing for Children in the Training School for Nurses from 1895 to 1898. Was made Professor of Obstetrics March 5, 1908, and Obstetrician to Freedmen's Hospital 1908, and held these positions until his death, May 10, 1915.

Dr. Perry suffered for many years with an epithelioma of the face. Some time between 1892 and 1895, a small ulcer appeared at the junction of the left ala of the nose and upper lip. It was treated successively with arsenic paste, sodium hydrate, the x-ray, nitrate of mercury, the actual cautery and radium. The most effective of these agents was the actual cautery, but in spite of all treatment the disease spread until finally it destroyed the entire nose and was progressing steadily toward the cranial cavity when death occurred. The nature of his affliction caused him to shun public gatherings and so prevented him from attending the meetings of this Society, to whose interests he was entirely devoted.

Your committee presents the following resolutions:

Resolved, That in the death of Dr. George Nelson Perry the Society has lost a loyal member, the profession an earnest worker, the Medical School a faithful and efficient instructor, the city a public spirited citizen, the family a devoted husband and father, who endured the sufferings of more than twenty years with patience and fortitude.

Resolved, That a copy of these resolutions be transmitted to his family, to whom the sympathy of the Society is herewith extended.*

E. A. Balloch,
D. S. Lamb,
Norman R. Jenner,
Committee.

DR. ERNEST PENDLETON MAGRUDER.

Whereas the Medical Society of the District of Columbia has heard with deep sorrow of the death of Dr. Ernest Pendleton Magruder, the following biographic sketch has been prepared :

Ernest Pendleton Magruder was born in Upper Marlboro', Maryland, October 23, 1871, and died in Belgrade, Serbia, April 8, 1915. After private instruction, he attended the Marlboro' Academy, spent a year in Georgetown University, then went to Deichmann's Preparatory School, Baltimore, before admission to the Johns Hopkins University ; from the latter institution he was graduated B. A., February 22, 1895. The remainder of the scholastic term was completed by him in courses of chemistry and biology offered by the University as post graduate work. In the following fall he was elected Superintendent of Schools in Williamsport, Maryland ; he next taught in Emerson Institute, this city, and later coached select classes of candidates for the larger universities of the country.

In 1900 he was given the degree of M. A. by Columbian (now George Washington) University, and in 1902 the degree of M. D. was conferred upon him. After receiving his medical degree he engaged in private practice until elected Superintendent of the Emergency Hospital, in which capacity he served until resigning the position four years later.

In 1910 he made a tour of Europe and Northern Africa, visiting the clinics of the most widely known surgeons of Paris, Berlin and Vienna ; and later those of the Mayo Brothers at Rochester, Minnesota.

While in Scotland he met Miss Maryel Alpina, youngest daughter of the late Sir Malcolm MacGregor of MacGregor, Rear Admiral, Royal Navy, and Lady Helen Laura, only daughter of

*Adopted by the Medical Society May 26, 1915.

Hugh Seymour, Earl of Antrim, and sister of Sir Malcolm MacGregor of MacGregor, Captain, Royal Navy, Chief of Clan Gregor, to whom he was married in Edinburgh, October 23, 1911.

Dr. Magruder was a frequent contributor to local medical literature, and among his published papers may be mentioned: "Case of Aortic Regurgitation and Floating Liver," *N. Y. Med. Jour.*, February, 1908; "Fracture of the Patella; the Operation of Choice," *Jour. Amer. Med. Ass'n.*, June, 1909; "Uraemia, with Terminal Cerebral Hemorrhage," *N. Y. Med. Jour.*, May, 1910; "Bone Grafting and Osteoplasty; a Case of the Latter Presented," *Surg., Gynec. and Obstet.*, August, 1910; "The Operative Treatment of Fractures," *N. Y. Med. Jour.*, December, 1911; "Volvulus," *Surg., Gynec. and Obstet.*, December, 1911. Some of these papers were reprinted in the medical journals of foreign countries.

Dr. Magruder was Associate Surgeon in Georgetown University and Emergency Hospitals, Professor of Clinical Surgery at Georgetown University, and was a member of the Medical Society of the District of Columbia, of the Medical Society of Northern Virginia and the District of Columbia, the George Washington Medical Society, the Washington Surgical Society, Fellow of the American Medical Association, and Fellow and one of the Founders of the American College of Surgeons.

In 1895 he was a delegate from the Johns Hopkins University Chapter to the Kappa Alpha convention held in Richmond, Va.; and was a member of the Washington Alumni Association of K. A., the Johns Hopkins University Alumni Society and the University Club.

He was an ardent fruit culturist, owning upward of 20,000 trees, mostly peaches, in Prince George's County, Maryland, and for many years was a Vice-president of the Maryland State Horticultural Society.

At the outbreak of the European War, Dr. Magruder offered his services to the American Red Cross, which organization made him treasurer of the three units sent to Serbia; also second Surgeon Director and Chief Surgeon of Unit 3, stationed at Gevgelija. With him was Dr. Ethan F. Butler, Surgeon Director and Chief Surgeon of Unit 2, while Dr. Edward W. Ryan, Chief Surgeon of Unit 1, was located at Belgrade. After four months service, three of the six surgeons and ten of the twelve nurses had been down with typhus, one of the former, Dr. James F. Donnelly, dying in March, when Dr. Magruder left the "pest hole" of Europe to attend Dr. Ryan who was ill of typhus. On the journey to Belgrade he was stricken with the same disease and died after five days illness. His patient, Dr. Ryan, at last reports was convalescent. Dr. Butler is the only surgeon sent to Serbia who has so far escaped the disease, while of eighteen surgeons and nurses comprising the three units but three have escaped the

epidemic. The Russian Red Cross Units have lost two surgeons, the British Red Cross, four surgeons, and the Dutch unit was so depleted by death that it was withdrawn, every member having contracted the disease. A cablegram from Dr. V. M. Soubotitch, General Secretary of the Serbian Red Cross, reads: "Our deepest condolences on Dr. Magruder's death at Belgrade. We ourselves have lost 105 doctors."

Dr. Magruder's body rests temporarily in Belgrade, where, because of our strict quarantine laws, it must remain for a year before being brought home for final interment.

In a letter to a member of his family, written two weeks before his death, Dr. Magruder said: " * * * the work has been so heavy altogether, converting buildings into hospitals, organization of the whole plant, sanitation, care of the wounded and sick (we began with 1,300 patients, mostly surgical. Serbians and Austrians, now upward of 3,000,) but the consciousness of the relief it has given to the awful suffering in its manifold manifestations has greatly lightened our labors." Another letter similarly addressed, reads: "I am looking after nearly 3,000 cases, operative and typhus, and for once in my life I have surgery to the full, yet it is not bullets but disease which makes it most dangerous here; various forms prevail, especially typhus, with cholera by no means a remote possibility. The native physicians, as well as the surgeons of other than the American Red Cross Units, and the people generally, are dying at an alarming rate, and Serbia is quite helpless to combat the scourge now spreading rapidly."

Dr. Magruder is survived by his widow and only child, Ernest P. Magruder, who joined her mother in Scotland when he started on his mission to Serbia. He was the son of Caleb C. Magruder, Clerk of the Court of Appeals of Maryland, and Elizabeth Rice Nalle, and grandson of Richard T. Nalle of Virginia, Doctor of Medicine of the University of Pennsylvania. His parents and four brothers reside in Maryland.

As a surgeon Dr. Magruder was studious, ingenious, careful, conscientious and thorough in his work. As a teacher he was logical and convincing. As a friend he was true and faithful, ever to be depended on. As a man he stood high in the purity of his life and in the possession of those qualities which bespeak true manhood. He may not have had the showy, catchy manners which often bring a fleeting popularity but he was loyal, truthful and just. Therefore be it

Resolved, (1) That in the death of Dr. Magruder this Society has lost a most worthy and valuable member.

(2) That while we lament his untimely death, we believe that his generous sacrifice will prove an inspiration to all true physicians.

(3) That a copy of this sketch and resolutions be spread on the

minutes of this Society and that copies be sent to the widow and parents of the deceased.

(Signed) GEORGE TULLY VAUGHAN, *Chairman.*
V. B. JACKSON,
D. G. SMITH.

At the meeting of the Medical Society of Northern Virginia and the District of Columbia, May 19, 1915, on motion of Dr. Meredith of Manassas, the resolutions adopted by the Medical Society of the District of Columbia in memory of Dr. E. P. Magruder were endorsed.

PROCEEDINGS OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Wednesday, April 7, 1915.—The President, Dr. Frank Leech, presided; about 125 members present.

The Treasurer reported for March, receipts, $117.00; disbursements, $232.88.

The Society appropriated $69.00 for rent of hall and use of stereopticon for the first quarter of the year.

Dr. G. Wythe Cook, Chairman of Executive Committee, reported the following resolution:

"*Resolved*, That in the opinion of the Medical Society a well-equipped laboratory is essential to the efficiency of the Health Office of the District of Columbia. Such a laboratory should be prepared to—

"(1) Examine food supplies.

"(2) Make biologic tests in appropriate cases for indigent persons, and also to make antitoxic and other sera and vaccines to be furnished at cost to those unable to pay the commercial prices for the same.

"(3) The Legislative Committee of the Society is instructed to carry into effect the provisions of the resolution."

The resolution was adopted, and the Legislative Sub-committee of the Executive Committee was instructed to seek the enactment of the necessary legislation, bringing the matter to the attention of the Commissioners within the next two months.

Dr. Cook also reported that a sub-committee on complaints of members concerning certain medical activities of the public services had recommended that the matter be discussed by the Society at its next meeting. The matter, however, was referred back to the Executive Committee for further inquiry and with instructions to invite all interested persons and the heads of the three public services to a hearing.

Dr. W. G. Russell, of Old Point Comfort, Va., presented moving pictures illustrating Hydrotherapy as practiced at his place.

Wednesday, April 14.—President Leech in the chair; about 100 members present.

The Society appropriated $36.68 for expenses of Corresponding Secretary, and $11.26 for postage of Committee on Publication.

Drs. Van Renssalaer, Hunt and Simpson were appointed a committee on entertainment of the visiting radiologists who should address the Society.

Dr. L. B. T. Johnson, of the Committee on Public Instruction, presented an amended report on Twilight Sleep; laid on the table.

A letter from Lt. Col. H. C. Fisher, Commandant of Army Medical School, containing the instructions of the Surgeon General, U. S. A., to resident army medical officers, intended to prevent unfair competition with civilian physicians, was referred to the Executive Committee.

The Surgeon General, U. S. A., stated that the Secretary of War had decided that if a citizen residing in the neighborhood of a military post desired the professional attendance of an army medical officer, it is not inconsistent with the requirements of the regulations governing the army for such officer to render his services, when this does not interfere with the proper performance of his official duties. But the establishment of an office outside of the limits of a military post for the purpose of engaging in civil practice is prohibited. This, of course, is with the understanding that government material is not expended for the purpose indicated. Army medical officers are informed that it is desired that they do not in any way enter into unfair competition with civilian physicians. It is therefore directed that in case the officer's professional services are sought by those not officially entitled to them, he should charge a fee at least as large as that required by the best class of physicians (including radiographers). The only exception to be made to this rule, is when after a thorough investigation it is determined that the patient is unable to pay the usual fee, in which case a proper reduction may be made a matter of charity. This should be in exceptional cases and only in accordance with the usual professional ethical procedure.

Drs. Vaughan, Jackson and D. G. Smith were appointed a committee on resolutions in regard to the death of Dr. E. P. Magruder.

Drs. Randolph and P. B. Johnson presented a specimen and case report of enormous *Auricular dilatation* of the *heart* with mitral stenosis and insufficiency. Discussed by Drs. J. D. Thomas, Johnson and Randolph.

Dr. J. D. Thomas presented a case report of *Chronic pleural effusion* and showed a specimen of the aspirated fluid in which was a deposit of cholesterin.

Wednesday, April 21.—President Leech presided; about 60 members present.

A letter in regard to cancer was referred to the Committee on Cancer.

The Executive Committee was instructed to consider some appropriate action to be taken by the Society in regard to the fiftieth year of practice of Dr. Joseph Taber Johnson.

An invitation from the Surgeon General, U. S. A., to attend two lectures by Dr. W. W. Keen, of Philadelphia, before the Army Medical School, was ordered to be announced on the program.

Dr. Alexander G. Brown, of Richmond, Va., addressed the Society on Blood pressure. Discussed by Drs. Lee, Roy, Nichols, Williams, Kober and Brown. A vote of thanks was given to Dr. Brown.

Wednesday, April 28.—President Leech in the chair; about 70 members present.

The Treasurer reported the following members in arrears for dues for more than two years, and their names were dropped from the roll: Drs. J. E. Bowers, W. W. Christmas, H. V. Johnston, E. C. Starr-Keith, J. F. McKaig and J. B. Spencer. The dues of the following members were remitted for the current year: Drs. F. L. Biscoe, S. W. Bogan, H. M. Deeble, F. M. Gunnell, W. P. McKee, C. V. Petteys, W. E. Poulton, H. M. Price, J. N. Reeve, W. W. Wilkinson, W. C. Williams and E. C. C. Winter.

Dr. Wall presented a plan for the study of infant mortality in this city; referred to Committee on Public Instruction.

A vote of thanks was given to the Surgeon General, U. S. A., for his invitation to the Society to attend the lectures of Dr. W. W. Keen.

Dr. T. A. Williams presented anew his patient with Amyotrophy and sensory loss, to demonstrate the clinical changes; and also reported a case of Thoracic tabes. Discussed by Drs. H. A. Bishop, Verbrycke, Hough, Simpson and Williams.

Dr. Hickling read a paper, The opium habit and its treatment. Discussed by Drs. Reisinger, P. B. Johnson, Chipman, Chappell, S. S. Adams, Atkinson, Williams and Hickling. See page 221.

Wednesday, May 5.—President Leech presided; about 75 members present.

The Treasurer reported for April, receipts, $23.00; disbursements, $288.58.

An invitation was directed to be given to Dr. A. Jacobi to the entertainment of May 12.

Dr. Cook, for the Executive Committee, recommended that a committee be appointed to plan a suitable celebration of Dr. J. Taber Johnson's semi-centennial in the practice of medicine.

Drs. S. S. Adams, Kober and Cook were appointed the committee.

The Executive Committee also recommended that W. C. Gorgas, Surgeon General, U. S. A., be nominated an honorary member, and that the nomination be signed by the Chairman, Vice Chairman and Secretary of the committee. The recommendation was adopted and the nomination was made.

The Committee on Publication was instructed to have printed 600 reprints of the list of members as published in the ANNALS for May.

Dr. Vaughan, from the Memorial Committee, reported a biographical sketch with resolutions in the case of Dr. E. P. Magruder. Adopted. See page 259.

The following were elected active members: Leslie Elmo Elliott, Amer. Med. Missionary College, 1904; Albert Elwood Pagan, G. W. Univ., 1912, and Eugene Arthur Taylor, Univ. Virginia, 1908, and as associate member: Arthur C. Christie, Captain Medical Corps, U. S. A.

The following were proposed for active membership: Ferdinand Henry Mistretta, Georgetown Univ., 1914; Edward Lloyd Morrison, Jefferson Medical College, 1905, and Wm. Clark Sparks, Univ. Virginia, 1908.

The proposed amendment to the By-Laws that "Members shall not smoke in the room where the Society is holding its meetings" was lost.

Dr. Randolph presented a case and specimen of Thrombosis of coronary arteries. Discussed by Drs. Trimble, Reisinger, J. D. Thomas and Randolph.

Dr. C. S. White read a paper, The physician's relation to the Coroner's Office. Discussed by Drs. Woodward, W. B. Carr, Chappell, G. W. Cook, E. L. Morgan, Reichelderfer and White. See page 242.

Wednesday, May 12.—President Leech presided; about 125 members present.

The Society appropriated $53.91 for expenses of Corresponding Secretary.

The following were appointed a committee on the death of Dr. G. N. Perry: Drs. Balloch, Lamb and Jenner.

Dr. Curtis H. Burnam, of Baltimore, addressed the Society on Roentgen treatment of uterine fibroids; Dr. George H. Johnston, of Pittsburgh, on the Roentgen ray treatment of tubercular glands and sinuses; Dr. George E. Pfahler, of Philadelphia, Pa., on Roentgen ray treatment of deep-seated malignant lesions, and Dr. Arthur F. Holding, of New York, discussed the previous addresses. A rising vote of thanks was given to the speakers.

The Society adjourned to the University Club where a smoker was had in honor of the speakers of the evening.

Wednesday, May 19.—President Leech presided; about 56 members present.

Dr. S. S. Adams, from the Johnson committee, reported the following resolutions, which were adopted, and the Corresponding Secretary was instructed to send a copy to Dr. Johnson and ask him to name a date that would be agreeable to him to attend a dinner in his honor. See page 257.

A letter was read from Dr. Craig, Secretary of the A. M. A., acknowledging receipt of the resolutions of the Society proposing to amend the By-Laws of the A. M. A. in regard to membership. The Corresponding Secretary was instructed to ask Dr. Craig to have the resolutions published.

Dr. Heitmuller moved that the Executive Committee be instructed to make proper representations to the Commissioners of the District of Columbia, urging them to include in the estimates for the next fiscal year provisions for adequately increasing the salary of the Coroner's office. Also to investigate the amount and character of the work performed by the various medical officers and employees of the District government, and the salaries of such positions, to determine whether the alleged inadequacy or discrimination exists; and to report its findings and conclusions to the Society immediately after the summer recess. Referred to the Executive Committee.

Dr. Vaughan reported a case of Hydatid cyst of liver and presented the specimen. Discussed by Drs. Constas, Verbrycke, Williams and Vaughan. See page 251.

Dr. Chipman reported two cases of Tracheotomy with recovery. Discussed by Drs. Seibert, Tibbetts, Wolfe, Vaughan and Chipman.

Dr. N. P. Barnes read a paper, Importance and injuries of the sesamoid bones of the metatarso-phalangeal articulation. Discussed by Drs. S. S. Adams, I. S. Stone, Vaughan, Chappell, I. H. Lamb, Wolfe and Barnes.

Wednesday, May 26.—President Leech presided; about 65 members present.

Dr. D. S. Lamb, from the committee, reported resolutions in regard to the death of Dr. G. N. Perry, which were adopted. See page 258.

Dr. G. Wythe Cook, from the committee on the semi-centennial of Dr. J. Taber Johnson, read a letter from Dr. Johnson expressing appreciation of the resolutions of the Society. See page 257.

An appropriation of $10.00 was made to cover the deficit remaining from the expenses of the recent smoker; also $34.64 for the expenses of the Corresponding Secretary.

The Treasurer was authorized to pay bills accruing during the summer recess.

Dr. C. W. Allen presented a specimen of *thoracopagus tribrachius*. Discussed by Dr. D. S. Lamb.

Dr. R. S. Lamb reported a case of sarcoma of the eye, treated by the x-ray. See page 253.

Dr. C. A. Simpson reported three cases of epithelioma, also treated by the x-ray. Discussed by Drs. Williams, Roy, Hazen, R. S. Lamb and Simpson. See page 254.

Dr. E. H. Reede read a Review of the advance in the knowledge of the thymus gland. Discussed by Drs. D. S. Lamb, Mallory, Williams, P. B. Johnson, Simpson, Roy, R. S. Lamb and Reede. See page 231.

The Society adjourned until October.

WASHINGTON MEDICAL ANNALS.

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Editorial.

HISTORY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.—Price $1.00, with 25 cents added if delivered in this city or sent by mail. Address Dr. C. W. Franzoni, 605 I Street, N. W. The books are in the custody of Dr. D. S. Lamb, at the Army Medical Museum.

THE WASHINGTON MEDICAL ANNALS, the official organ of the Medical Society of the District of Columbia, issued the first of January, March, May, July, September and November, will publish gratuitously such information of a medical, surgical and sanitary character, changes in personnel, &c., of hospitals, dispensaries, medical schools, medical societies and other medical agencies, as would be useful and interesting to the members of the Society. Address the Chairman of the Committee on Publication, Dr. D. S. Lamb, 2114 Eighteenth St., N. W.

THE WASHINGTON MEDICAL ANNALS.—Back numbers.—Members of the Society who have back numbers of the ANNALS, and do not intend to preserve them, are requested to send them to the Chairman of the Publication Committee. Requests for such numbers are frequently received. Address Dr. D. S. Lamb, Army Medical Museum.

THE OTHER MEDICAL SOCIETIES OF THE DISTRICT OF COLUMBIA.

ALUMNI MEDICAL SOCIETY OF GEORGETOWN UNIVERSITY.—Active membership, 100; meets on the third Saturday of the month at the Medical School. Officers: J. A. Gannon, President; L. A. Martel and, T. F. Lowe, Vice Presidents; C. I. Griffith, Recording Secretary; J. M. Moser, Corresponding Secretary; C. E. O'Connor, Treasurer.

CLINICAL SOCIETY.—Officers: F. L. Biscoe, President; W. J. Mallory, Vice President; E. P. Copeland, Secretary-Treasurer; Censors: L. A. Johnson and J. D. Thomas.

1915.	*Meeting Place.*	*Essayist.*	*Discussion by.*
October 12	Dr. J. D. Thomas	Dr. C. S. White	Dr. Reichelderfer.
November 9	Dr. E. P. Copeland	Dr. W. A. Wells	Dr. Richardson.

CLINICO-PATHOLOGICAL SOCIETY.—Active membership limited to 25. Inactive membership: those who have withdrawn from active membership after fifteen years. A limited honorary membership of eminent medical men. Meets on the first and third Tuesdays of the month from October to May, inclusive. Officers: President, J. D. Thomas; Vice Presidents, Loren Johnson and H. P. Parker; Secretary and Treasurer, B. M. Randolph.

FREEDMEN'S HOSPITAL MEDICAL SOCIETY.—Meets on the second Wednesday of each month from October to May, inclusive. Composed of physicians connected with the Staff of the Hospital and the Medical Faculty of Howard Medical School. E. A. Balloch, President; S. L. Carson, Vice President; C. A. Allen, Secretary-Treasurer; Committee on Program, E. A. Balloch, S. L. Carson and H. H. Hazen.

GALEN SOCIETY of the District of Columbia.—Wm. H. Littlepage, President; Harry A. Ong, Secretary.

1915.	*Place.*	*Essayist.*
October 18	Dr. Pfender	Business Meeting.
	304 Rhode Island Avenue, N. W.	President's Address.
November 15	Dr. Henning	Dr. Pfender.
	The Rochambeau.	
December 20	Dr. Titus	Clinical.
	1730 M Street, N. W.	

GEORGETOWN CLINICAL SOCIETY; twenty-five active members, limited to graduates of the Medical Department of Georgetown University. Meets at the University Club on the third Tuesday in the month. John Foote, President; J. Russell Verbrycke, Jr., Treasurer.

HIPPOCRATES SOCIETY, membership limited to 25, with voluntary retired members after 10 years, meets on the second Thursday of the month from October to May. Officers for the year: J. R. Verbrycke, Jr., President; C. A. Simpson, Secretary.

MEDICAL HISTORY CLUB of Washington, D. C.—Officers: President, Philip Roy; Vice-President, F. H. Garrison; Secretary, John Foote; Executive Committee, I. S. Stone, H. W. Lawson, Wm. A. White and the Officers. Members: Truman Abbe, Frank Baker, W. C. Borden, Joseph H. Bryan, G. Wythe Cook, John Foote, F. H. Garrison, Howard Hume, H. W. Lawson, W. J. Mallory, G. Brown Miller, J. D. Morgan, John B. Nichols, P. S. Roy, I. S. Stone, John D. Thomas, Wm. A. White, W. W. Wilkinson, Mathew Kollig.

MEDICAL AND SURGICAL SOCIETY of the District of Columbia.—President, John Dunlop; Vice President, H. H. Hazen; Secretary and Treasurer, L. Eliot; Asst. Secretary, L. C. Ecker; Executive Council, O. A. M. McKimmie, E. L. Morgan, L. Eliot, L. H. Reichelderfer and Ecker.

SOCIETY OF MEDICAL JURISPRUDENCE, Washington, D. C. —President, Dr. Wm. A. White; Vice President, R. Ross Perry; Secretary-Treasurer, Dr. D. P. Hickling. Meets on the second Monday of each month from October to June at University Club. Has from forty to fifty members.

SOCIETY OF OPHTHALMOLOGISTS AND OTOLOGISTS, Washington, D. C., meets the third Friday of each month from October until May, inclusive.

Officers: President, A. B. Bennett, Jr.; Vice President, A. H. Kimball; Secy.-Treasurer, Carl Henning, The Rochambeau.

Active members: A. B. Bennett, Jr., J. W. Burke, V. Dabney, W. T. Davis, L. S. Greene, C. M. Hammett, Carl Henning, E. B. Jones, A. H. Kimball, R. S. Lamb, F. B. Loring, O. A. M. McKimmie, W. B. Mason, M. E. Miller, Mead Moore, S. B. Muncaster, W. S. Newell, J. J. Richardson, E. G. Seibert, R. R. Walker, W. A. Wells.

Inactive members: J. H. Bryan, W. K. Butler, H. S. Dye, Wm. H. Fox, W. P. Malone, H. A. Polkinhorn, C. W. Richardson, D. K. Shute, W. H. Wilmer.

Schedule of Meetings—1915–1916.

	Residence of:	*Paper on Eye by:*	*Paper on Ear or Throat by:*
October	Dr. Henning	Dr. Lamb	Dr. McKimmie.
November	Dr. Mason	Dr. Loring	Dr. Wells.
December	Dr. Miller	Dr. Green	Dr. Walker.
January	Dr. Loring	Dr. Muncaster	Dr. Miller.
February	Dr. Richardson	Dr. Hammett	Dr. Moore.
March	Dr. Seibert	Dr. Newell	Dr. Richardson.
April	Dr. Hammett	Dr. Seibert	Dr. Jones.
May	Dr. Wells		Business meeting.

Society for Mental Hygiene, District of Columbia.—Organized at the New Willard June 3, 1915. Temporary President, Dr. Wm. A. White; temporary Secretary, Dr. D. P. Hickling. Organizing Committee: Surgeon General Rupert Blue, U. S. P. H. S., Miss Julia C. Lathrop, and Drs. White, Hickling and Frank Leech. The object of the Society is to work for the conservation of mental health, the prevention of mental disease and deficiency, and improvement in the care and treatment of those suffering from nervous and mental disease and mental deficiency.

Society of Social Hygiene, Washington, D. C.—President, Surgeon General Stokes, U. S. Navy; Secretary, Lt. Col. J. R. Kean, U. S. Army, Surgeon General's Office. The Society has four committees, namely: Education, Venereal Diseases, Protection of Women and Children, and Psychopathology. Yearly dues, $1.00. Persons desiring to become members should address Col. Kean and state to which committee they wish to be assigned.

Therapeutic Society of the District of Columbia.—Meets at the G. W. School of Pharmacy, 808 I Street, N. W., on the first Saturday in each month. G. W. Latimer, President; A. P. Tibbets, Secretary.

Walter Reed Medical Society meets on the fourth Thursday of every other month, from September to May inclusive. Composed of physicians located in the eastern part of Washington. Officers: J. S. Arnold, President; H. R. Schreiber, Vice President; M. H. Prosperi, Secretary; N. E. Webb, Treasurer.

Washington Medical and Surgical Society.—President, N. D. Graham; Vice President, R. R. Walker; Secretary, Walter Van Sweringen; Treasurer, F. E. Gibson; Curator and Librarian, E. H. Egbert; Executive Committee: L. H. Taylor, Chairman, G. S. Clark, G. S. Barnhart; Program and Auditing Committee: Wm. A. Jack, Jr., Chairman, J. R. Nevitt, Walter Van Sweringen; Membership Committee: F. E. Gibson, Chairman, Wm. P. Reeves, Caryl Burbank.

Program—1915.

Essayist.	*Date and Host.*	*To open Discussion.*
President's Address	October 25, Dr. Emmons	Dr. Braden.
Dr. Taylor	November 22, Dr. Frankland	Dr. Burbank.
Dr. Van Sweringen	December 20, Dr. Gibson	Dr. Clark.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY. —President, J. F. Moran; Vice Presidents, G. B. Miller, Prentiss Willson; Secretary, Truman Abbe; Treasurer, D. W. Prentiss. Retired members—G. N. Acker, S. S. Adams, E. A. Balloch, J. W. Bovée, W. S. Bowen, W. P. Carr, G. Wythe Cook, M. F. Cuthbert, H. D. Fry, H. L. E. Johnson, J. T. Johnson, D. G. Lewis, A. R. Shands, E. E. Morse, Elmer Sothoron, J. Ford Thompson, John Van Rensselaer.

Program—1915.

Date.	*Essayist.*	*Reporters.*	*Host.*
October 8	Dr. J. F. Moran	President's Address Election of Officers.	Dr. Lowe.
November 12	Dr. S. L. Owens	Dr. Karl Corley Dr. R. Y. Sullivan.	Dr. Prentiss.
December 10	Dr. John Foote	Dr. L. A. Martel Dr. C. S. White.	Dr. Riggles.

WASHINGTON SOCIETY OF NERVOUS AND MENTAL DISEASES. —President, Wm. H. Hough; Vice President, Bernard Glueck; Secretary, J. J. Madigan. The Society has a limited membership of thirty, but welcomes Physicans and Surgeons interested in Neurology and Psychiatry. Meets monthly on the third Thursday at the Cosmos Club or a member's residence.

WOMEN'S MEDICAL SOCIETY of the District of Columbia. —President, Sophie Nordhoff-Jung; Vice President, Ada R. Thomas; Secretary and Treasurer, A. Frances Foye; Corresponding Secretary, Margaret R. Stewart.

THE SECRETARIES of the other Medical Societies of this District are reminded that the ANNALS will publish the schedules of their meetings.

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS.—The following amendments have been made since the publication in Volume XII, March, 1913.

Constitution.—Article V, Section 4; adopted Nov. 4, 1914: before the words "Due notice" on page 142, insert "No application for membership that is rejected or withdrawn shall be renewed until after two years from the time of its rejection or withdrawal."

Section 10, same article; adopted Jan. 7, 1914: for "two years" substitute "one year."

Article VI, Section 5, adopted Jan. 6, 1915: in the last line, for "two" substitute "three."

Article VIII, Section 2, page 148, 4th line from top: for the word "disorders" substitute the word "diseases."

By-Laws.—Article VIII, Section 9, page 153: adopted Jan. 7, 1914: No member of the Staff of any hospital receiving patients in private rooms shall attend such private patient sent to the hospital by a member of the Society, not a member of the Staff, unless specifically requested to do so by the attending physician.

Please note that the figures in Sections 7 and 8 of this article, instead of being 7 and 8 should be 5 and 6.

Dr. T. A. Williams, 1705 N St., N. W., a committee on collecting instruments for Belgian Physicians, will be glad to receive any instruments that members of the Society can spare, however old such instruments may be. Kindly send to Dr. Williams or notify him that you can contribute them.

Belgian Scholarship Committee, Washington, D. C.—In consequence of the devastation of Belgian museums, libraries and universities, numerous worthy students, research workers and professors, many of them crippled for life, are interrupted in their important work. To the lovers of equity and to those who cherish education and admire Belgian integrity and heroism an opportunity is hereby given to assist in bringing to America worthy intellectual men and women for a temporary free enjoyment of the privileges of American institutions.

This committee has already received assurances from the George Washington University for the instruction of ten students in any of the departments of the University. It is highly probable that the committee will receive from other American institutions similar assurances.

It is proposed to raise a fund at once to defray the traveling expenses to and from Belgium and the cost of residence in Washington for a period of one year of the students or research workers which the George Washington University has already generously provided for. In the case of professors it is hoped that the subscriptions will be sufficiently liberal to provide for honorariums as well, thereby giving all the students in Washington the benefits of lectures by Belgian scholars.

It is estimated that from $20,000 to $25,000 will be needed in the work at once, and in the event of a surplus being accumulated, it is proposed to apply this to the recuperation of educational work in Belgium. This committee is a subcommittee of the Central Committee for the Belgian Relief Fund for Women and Children and other noncombatants, and it is organized with the approval of his Excellency, the Minister from Belgium to the United States.

Please draw checks payable to Belgian Scholarship Committee, John Joy Edson, Treasurer, Washington Loan and Trust Build-

ing, Washington, D. C. Checks for any amount, large or small, are earnestly asked for.

BELGIAN RELIEF.—George W. Crile, of Cleveland, says: "When I was in Belgium I received first-hand information from a number of Belgian physicians concerning their plight. They are indeed in dire need, and there seems to be no way by which this need can be overcome until their land is restored to them again. The free masonry of the medical profession so binds all medical men together that it seems to me that no appeal to doctors for the aid of their associates in Belgium can be in vain. We should all realize also that no single appeal can satisfy what is going to be a long continued need; that we must give now, later again, and still later, and so answer repeated appeals until later conditions may restore to the Belgians the wherewithal to aid themselves."

Dr. J. Riddle Goffe, of New York, says that in a letter just received from Dr. Jacobs, of Brussels, the latter summarizes the situation of our Belgian colleagues as follows:

1. Many doctors were killed, consequently the widows and orphans, deprived of everything, are without a home, without means, with nothing left. 2. All country doctors or those living in small towns are ruined by loss of every possession they had. 3. Doctors in large cities are ruined by commandeering, war levies, etc. 4. The largest part of Belgian population has become the prey of infectious diseases, epidemics, with a large infant mortality, etc. 6. Ruined civilian populations cannot pay for medical advice, consequently several physicians are compelled to work for nothing, others are obliged to undertake any labor for gain as a means of livelihood with results that are terrible for the population.

The opportunity is here created for the medical profession of the world to show the brotherly feeling which exists among them, and they can do this by helping with the necessary funds.

PRIZE.—The American Social Hygiene Association has been offered a prize of $1,000 by the Metropolitan Life Insurance Company, to be awarded to the author of the best original pamphlet on social hygiene for adolescents between the ages of twelve and sixteen years, approved by a committee of judges to be selected by the Association. Competition for the prize is open to all. The contest will close July 31, 1915, at midnight. Manuscripts should not exceed 3,500 words; must be in English; must not have been previously published; must be typewritten on one side only of plain white paper 8 inches by 10½ inches; must be paragraphed and punctuated for submission as "copy" to printer; must bear some identifying mark or pen-name, but not the name of the author. The author's name and address and the identifying mark or pen-name should be in a sealed envelope, accompanying the manuscript; the face of the envelope should bear the

mark or pen-name only. More than one manuscript may be submitted by the same author. The winning manuscript, in consideration of the award of $1,000, becomes the property of the donor of the prize, all rights therein being surrendered by the author. The right to purchase any manuscript submitted, at the rate of 5 cents a word, is reserved by the Metropolitan Life Insurance Company and by the American Social Hygiene Association. Any manuscript not winning the prize or purchased will be returned to the author if return postage is provided.

Address manuscripts and requests for further information to the American Social Hygiene Association, 105 West 40th Street, New York City.

Gorgas Prize Medal.—To be awarded yearly for the paper which shows the most important advances in medicine or surgery, on a medical or medico-military subject, preference being given to papers on medico-military subject. Only for papers of exceptionable value. Competition is open to medical officers of the Army, Medical Reserve Corps of the Army, and medical officers of the organized militia. The prize is given by the Association of the Medical Reserve Corps, U. S. Army, New York State Division. The Board of Award consists of three members of the Faculty of the Army Medical School appointed by the Surgeon General of the Army. The papers to be submitted by March 31st of each year, to the President of the Board of Award, Gorgas Prize Medal, Army Medical School, Washington. The award to be announced at the graduation exercises of the School May 31st.

Annual Dues.—The annual dues of several medical societies in Pennsylvania are as follows: Lawrence County Society, $5.00; Erie County, $7.00; Lackawanna County and Luzerne County each, $10.00.

Department of Health, Pennsylvania.—Dr. Samuel G. Dixon has been reappointed Commissioner of Health; his fourth appointment; now ten years of service in the Department. Under his direction the Department has done much good work and has attained a high position in public health organizations. There are between three and four thousand employees. Tuberculosis dispensaries to the number of 115 have been established and three great State sanitoriums; and tuberculosis now has second instead of first place as a cause of death. Typhoid fever has decreased more than 75 per cent. The death rate last year was for the State 13.5, the lowest in its history.

American Association of Medical Jurisprudence.—Organized May 3, 1913; incorporated Dec. 5, 1913. President, Dr. D. P. Hickling of this city; First Vice President, O. W. Ehrhorn,

N. Y. City; Second Vice President, Dr. P. C. Knapp, Boston, Mass.; Secretary, C. P. Blaney, N. Y. City; Treasurer, J. C. West, N. Y. City.

CANCER.—Dr. L. Duncan Bulkley, of New York City, has just published a book entitled "Cancer, its cause and treatment;" printed by P. B. Hoeber, 67, 69 East 59th St., N. Y. City. Price, $1.50 net. 12mo, 230 pages. He has also made a folder containing suggestions in regard to cancer and a diet list for its prevention and treatment.

THE MEDICAL LIBRARY ASSOCIATION.—This Association has been in existence for eighteen years and has filled a unique place among Medical Libraries. The work is largely altruistic, as Libraries interested do all in their power to help each other. The membership fees are small and expenses are kept at the lowest possible amount consistent with the service rendered. By careful husbanding of funds the Treasurer's report shows a very substantial balance which will allow a broadening out in the work this year. It is for this reason that the officers wish to interest a wider field. There are at present 52 library members and 46 individual members; all the older large Libraries being affiliated and glad to give to the newer small Libraries from their material without any proportionate return. The officers are: President, Lieut. Col. C. C. McCulloch, Jr., Library Surgeon General's Office, Washington, D. C.; Secretary and Treasurer, Dr. John Ruhräh, 1211 Cathedral St., Baltimore, Md.; Manager of the Exchange, Miss M. C. Noyes, 1211 Cathedral St.

THE HOSPITAL NEWS.—We have received the May number. There is no question as to its handsome appearance; the paper, the printing, the cover and the illustrations are excellent, the x-rays unusually distinct; so much for appropriate paper. The reading matter is interesting; the Interne and Nurse service is informing and ought to be helpful; it looks like a good deal of work for Dr. Gannon. Many advertisements; should be quite a source of income. Mixing up advertisements with reading matter does not commend itself to us.

REVIEW.

SURGERY OF THE BLOOD VESSELS; by J. SHELTON HORSLEY, M. D., F. A. C. S., Richmond, Va.; published by C. V. MOSBY Co., St. Louis, Mo. Price $4.00.

This book of about 300 pages gives a good account of the present status of blood vessel surgery. There are 16 chapters and 89 illustrations. The subjects comprise the structure and histological repair of blood vessels, history of blood vessel surgery,

indications for suturing, technique of suturing, lateral anastomosis and reversal of circulation, transfusion of blood, hemorrhage, thrombosis and embolism, treatment of occlusion of blood vessels, resection and transplantation of intestine, aneurisms, tumors of vessels, varicose veins, varicocele and hemorrhoids.

The chapters on the technique of suturing blood vessels and on the transfusion of blood are especially interesting. The author prefers the double mattress or cobbler's stitch to the glover's suture used by Carrel and others in uniting the edges of the vessels, as the latter is more apt to tear out in vessels with brittle walls and is more likely to be followed by bleeding. The cobbler's stitch is obviously more troublesome to introduce, but with the aid of the author's ingenious invention, the "arterial suture staff," the difficulty is materially reduced. The reversal of the circulation he considers of doubtful utility, but if it is done he advises the lateral, and not the end-to-end, anastomosis of the artery and vein, as the former gives two channels for arterial blood instead of one and the original arterial channel is not sacrificed.

Sound views are expressed on the subject of the transplantation of limbs and other organs. Quoting Lexer, who after considerable experience in this line concludes that such transplantations promise practically nothing, the author says, "A kidney transplanted from one dog to another may functionate for a while, but sooner or later the fine differences of serum and tissue destroy the organ and prevent ultimate success. However, while complicated glands cannot be transplanted, simple tissue can often be permanently grafted from one animal to another, or particularly from one portion of an animal or person on another portion of the body. The simple function of a transplanted blood vessel can be maintained, and it is probable that at least the endothelial and connective tissue of the transplanted vessel is permanent."

The history, indications for, and various methods of, transfusion of blood are well set forth and the technique clearly described. The author prefers the method by direct anastomosis of artery to vein. His statement that in "anemia due to loss of normal blood, transfusion gives brilliant results and is practically a specific" will be generally indorsed, and yet the question will arise as to whether a simple infusion of salt solution would not be equally efficient. On the whole the book is well writtten, clearly printed and deserves a place in the library of every surgeon.—G. T. Vaughan.

The Old Posterior Operation. — "I see they have operated on a Philadelphia boy's head to make a better boy of him."

"That isn't where my dad used to operate on me to make a better boy of me."—*Houston Post.*

RECENT PUBLICATIONS OF PHYSICIANS IN THE DISTRICT OF COLUMBIA.

J. F. Anderson ; Typhus fever ; *Jour. Arkansas Med. Soc.*, May, page 282.

Bovée ; Surgical treatment of retroversion of uterus with special reference to lower pole ; *Surg. Gynec. and Obstet.*, May.

H. H. Bunzel ; Alfalfa laccose ; *Jour. Biol. Chem.*, April.

T. A. Claytor ; Multiple neuritis as complication or sequel of typhoid ; *Amer. Jour. Med. Sci.*, May ; abstracted in *Jour. A. M. A.*, May 22, page 1793.

C. B. Conklin ; A plea for the specialist in anesthesia ; *Va. Med. Semi-Mo.*, June 11, page 116.

E. P. Copeland ; Cases of pyelitis in the young ; same journal, June 25, page 140.

L. Eliot ; Pruritus ani ; *Ibid.*, page 137.

J. R. Ernst ; Importance of early recognition of mental limitations of praecox type ; *Med. Record, N. Y.*, May 29.

H. M. Evans ; Macrophages of mammals ; *Amer. Jour. Physiol.*, May.

F. H. Garrison ; John Shaw Billings ; New York ; reviewed in *Jour. A. M. A.*, May 22, page 1784.

F. R. Hagner ; Chronic prostatic cystitis ; *Va. Med. Semi-Mo.*, June 25, page 146. Also Bichloride poisoning ; *Ibid.*, page 147.

M. C. Hall ; Taenia saginata ; *Jour. A. M. A.*, June 12, page 1972.

G. H. Heitmuller ; Dental clinics ; same journal, June 26, page 2158.

G. I. Jones ; Intestinal amebiasis ; same journal, March 20, page 982 ; abstracted in *Jour. Kans. Med. Soc.*, May, page 165.

G. M. Kober ; Cincinnati's proposed health center ; *Lancet-Clinic*, May 8.

R. S. Lamb ; Subperiosteal blood cyst of orbit simulating osteosarcoma ; *Ophthalmology*, April.

H. Laveson ; Proper factory ventilation and its effects on workers ; *N. Y. Med. Jour.*, May 8.

L. L. Lumsden ; Typhoid fever, its causation and prevention ; Public Health Bull., No. 69, May.

L. L. Lumsden, C. W. Stiles and A. W. Freeman ; Safe disposal of human excreta at unsewered homes ; Public Health Bull., No. 68, April.

Med. and Surg. Society, D. C. ; *Va. Med. Semi-Mo.*, June 25, page 146.

H. W. Miller ; Sanitariums and sanatoriums ; *Hospital News*, May, page 31.

S. B. Muncaster ; Causes of second sight ; *Ophthalmology*, April.

Philip Newton ; With the Red Cross in Russia ; *Hospital News*, May, page 15.

Municipal ordinances, rules and regulations, pertaining to public health. Adopted during 1913 by cities of the United States, having population over 10,000 in 1910. Reprint 230 from Public Health Reports. Also, State laws and regulations pertaining to public health. Adopted between July 1, 1911, and Dec. 31, 1912. Reprint 200 from Public Health Reports.

W. C. Rucker; The menace of bubonic plague to American seaports; *Maryland Med. Jour.*, June, page 144.

J. H. Selby; X-rays, their uses and dangers; *Hospital News*, May, page 5.

C. A. Simpson; The prevention of cerebro-spinal syphilis; *Va. Med. Semi-Mo.*, May 7, page 60.

J. O. Skinner; Anthrax; *Hospital News*, May, page 34.

F. C. Smith; Effects of altitude on blood pressure; *Jour. A. M. A.*, May 29, page 1812.

Camp Stanley; Duodenal alimentation; *South. Med. Jour.*, May.

E. A. Sweet; Interstate migration of tuberculous persons; reprint 269 from Public Health Reports, April.

E. B. Vedder; Starch agar, useful culture medium; *Jour. Infect. Dis.*, May; abstracted in *Jour. A. M. A.*, June 19, page 2096.

W. A. Wells; The new municipal hospital of Cincinnati; *Hospital News*, May, page 23.

M. I. Wilbert; The purity and strength of household remedies; Public Health Reports, Jan. 29; abstracted in *South. Med. Jour.*, June, page 497. Also, Efforts to curb the misuse of narcotic drugs; reprint 267 from Public Health Reports, March 26.

H. W. Wiley; Wealth of health; *South. Med. Jour.*, May.

T. A. Williams; Treatment of epilepsy from metabolic disturbances in adolescents; *Med. Record, N. Y.*, May 8. Also, The antecedents of high blood pressure and nervousness; *West Va. Med. Jour.*, May, page 363. Also, Misdiagnosed cases of compression of the spinal cord; *Va. Med. Semi-Mo.*, May 7, page 60, June 11, page 117, and June 25, page 142.

W. H. Wilmer; Sclerocorneal trephining in glaucoma; *South. Med. Jour.*, May.

PERSONAL NOTES.

Dr. G. N. Acker, President American Pediatric Society; annual meeting at Lakewood, N. J., May 24 to 26.

Dr. S. S. Adams attended the same meeting and took part in the discussions.

Charles B. Beall, father of Dr. Charles M. Beall, of this Society, died May 22.

Dr. J. W. Bovée attended the annual meeting of the Amer. Gynec. Society at White Sulphur Springs, West Va., May 18 to

20, took part in discussion, and read a paper on the "Use of the galvanocautery knife for excision of mammary tumors for microscopic diagnosis."

Dr. C. R. Dufour attended the meeting of the Southern Medical Association at Richmond, Va., Nov. 9 to 12, 1914, and took part in the discussions.

Dr. W. T. S. Duvall was elected a member of the Medical Association, D. C., October 4, 1870. Was dropped n. p. d. April 3, 1888. June 30, 1870, he and Surgeon Basil Norris, U. S. Army, each paid $1.00 to the Treasurer of the Society but they were never elected members; at any rate there is no record of election and their names do not appear in any list of members. Dr. Duvall was born in Washington; graduated M. D. Georgetown, 1865. Died May 16, 1915, at Garfield Hospital after an illness of more than a year; 80 years old.

Dr. L. L. Friedrich, a member of this Society since April 2, 1884, died June 15. A brief sketch of him appears in the history of the Society, page 318.

Dr. A. Y. P. Garnett was married June 12 to Miss Mildred Poor of East Hampton, L. I.

Dr. F. E. Harrington has been doing medical survey work for the Public Health Service during May and June in Orange County, N. C., visiting individual homes, and making public addresses in churches, schools, court houses, and at other public meetings. It is said that much interest in sanitary matters has been aroused through the county.

Dr. D. P. Hickling, at the annual meeting of the American Association of Medical Jurisprudence, was elected President. The meeting was at Hotel Trouville, Long Beach, N. Y.

Dr. Jos. Taber Johnson in January, 1914, resigned all his college and hospital appointments. After practicing medicine in Washington for fifty years, he sold his property in Washington and changed his address to Cherrydale, Alexandria County, Va., where he is now living the life of a farmer. Upon the acceptance by the Georgetown Medical School of his resignation of his professorship, which he had held for forty years, he was elected Emeritus Professor of Gynecology and Abdominal Surgery. Dr. Johnson also resigned his fellowship in the Southern Surgical and Gynecological Association, of which he was President in 1899; and was elected an Honorary Fellow at the meeting at Asheville, N. C., in December, 1914. He also resigned his Fellowship in the American Gynecological Society of which he was one of the founders, and was President in 1899, and was elected an Honorary Fellow at the meeting at White Sulphur Springs, W. Va., May, 1915. At the general Commencement of the Georgetown University in June, 1914, the University conferred on him the honorary degree of LL. D. He delivered the Commencement address to the graduating class of the Georgetown

Hospital Training School for Nurses, June 8, 1915. He was elected by the University Alumni a member of the Board of Regents to serve for three years from June, 1915. He was one of the founders of the American College of Surgeons and was elected a member of the Board of Governors for 1915. The members of the Medical Society wish for Dr. Johnson, many years of health and happiness.

Dr. T. C. Martin attended the annual meeting of the American Gastro-enterological Association in Baltimore, May 10, and took part in the discussions.

Dr. E. C. Prentiss is a member of the Milk Commission at El Paso, Texas.

Dr. Oscar Wilkinson read a paper before the Page County Medical Society at Front Royal, Va., April 13.

Medical Society of Northern Virginia and the District of Columbia. Meeting at Alexandria, Va., May 19; W. P. Carr, President; J. B. Nichols, Vice President; T. A. Groover, Recording Secretary; J. D. Rogers, Corresponding Secretary.

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WASHINGTON
MEDICAL ANNALS

CASE OF THROMBOSIS OF CORONARY ARTERY.*

By B. M. Randolph, M. D.,

Washington, D. C.

White man, aged 40; had had typhoid fever ten years previously. Used alcohol in moderation. During the last four years he had several attacks of cardiac pain, following exercise, as tennis, bowling, etc. The severity of these attacks progressively increased. They were of anginoid type, giving a sensation of compression of the heart, with intense pain in that organ, and referred pain in the left arm, shoulder and side of the neck and head. He had had a severe attack five days before death. This attack subsided, and was followed by another, forty-two hours before death, also brought on by playing tennis. At this time he vomited blood.

I first saw him, in consultation with Dr. R. S. Trimble, the morning after the onset of this last attack. The patient presented an anxious, drawn, pallid face, and was evidently in great distress. There was marked dyspnoea. Physical examination showed the apex beat of the heart just to the left of the sternum, opposite the junction of the gladiolus and xiphoid. This anomalous situation of the apical impulse was not due to displacement of the heart, as the left border of dulness reached nearly to the left nipple line. The right border could not be determined. The area occupied by the right auricle was distinctly enlarged. Auscultation revealed no valvular defects. The sounds were weak and thin. There was an area of dulness extending from the apex of the right lung to the fourth rib anteriorly; posteriorly, to the inferior angle of the scapula. At the beginning there was friction over the anterior border of the right lung at the level of the third rib. This was not heard later. Over this lobe the auscultatory sounds were those of pneumonic consolidation, *i. e.*, increased tactile fremitus, bronchial voice and whisper, bronchial breathing, crepitant râles. Over the rest of the pulmonary area there was greatly exaggerated breathing, and a variety of adventitious sounds. It was noted that the heart sounds could be best heard

* Reported to the Medical Society, May 5, 1915.

posteriorly over the region of the liver. There was much cough, and a sputum freely tinged with blood. Pulse 80; blood pressure 150.

A diagnosis was made of failure of the right heart, with pulmonary consolidation, due to infarct, or to passive congestion. The differentiation was made from pericardial effusion by a study of the cardiac area, and from pneumonia by the history. Coronary thrombosis was assigned as a probable cause, but this diagnosis was not definitely made.

Clinical Course.—The patient continued very restless, coughed a great deal, and expectorated bloody sputum. Dyspnoea and heart rate increased progressively, until death occurred on the afternoon of the third day in the hospital. On the evening of admission the temperature rose to 100, subsiding to 99 the next day, and to subnormal the day of death. The urine showed a trace of albumen, and a high specific gravity (1.031). Leucocytes were 19600. Wassermann *plus*.

Autopsy.—Section was made one and a half hours after death. Except a diffuse atheroma, there was nothing of interest outside the thorax. Heart moderately enlarged. The walls of the left ventricle were thickened, especially the inter-ventricular septum, which so encroached on the cavity of the right ventricle as to greatly distort it. There were no organic valvular defects. The right ventricle was dilated and distorted, as just mentioned; the tricuspid ring was relaxed. The left auricle was dilated. The coronary arteries were the seat of advanced atheroma throughout. In the right coronary, about midway between its origin and the apex of the heart, was a thrombus.* Microscopic examination of the vessel at this point by Dr. Hunter, Pathologist in Medical Department of George Washington University, showed disorganization of red cells, deposits of hemosiderin, and the beginning formation of fibrous tissue. It is thus determined that the thrombosis occurred some time before death. The middle lobe of the right lung was rudimentary, its place being taken by the correspondingly enlarged upper lobe. This upper lobe was the seat of passive congestion throughout. There was a small area of fibrinous interlobar exudate at its inner anterior aspect.

Dr. Trimble said that one interesting feature of the case was that the man, 41 years of age and looking younger (he looked to be 35 or 36) should have had such extensive arteriosclerosis. He was a flat-chested man, but had always been healthy, except for an attack of typhoid fever ten years ago. He had at one time used alcohol to excess, but latterly had taken only beer occasionally. While playing tennis he was seized with a cardiac pain for which he sought relief; he presented the typical symp-

* Microscopic examination had not been made at time of presentation of specimen to the Society, is now incorporated for sake of completeness.

toms of angina pectoris. Dr. Trimble advised bed rest, and prescribed nitroglycerine and digitalis; the first for the immediate symptoms, and the latter on account of the wavy pulse. The man did not go to bed as advised; on the contrary he played tennis again and at night went to work, where Dr. Trimble was called to see him. He was then in collapse and had a frightful state of dyspnoea and anxiety.

Dr. Reisinger said that the presentation of this case was of great value. We are too prone in cases of sudden death to write a certificate in general terms; we should insist upon an autopsy. This case was most instructive.

Dr. J. D. Thomas said that, judging from the specimen, it seemed doubtful to him whether the clot in the coronary vessels was the cause of death. The clot was soft and possibly developed post mortem. There was enough arteriosclerosis to account for the anginal symptoms without assuming thrombosis as a cause. It seemed to him most probable that the actual cause of death was acute dilatation after the tennis game. Whether the clot was of ante mortem origin could be determined by section.

Dr. Randolph said that Dr. Thomas was perfectly right in regard to the dilatation being the immediate cause of death. But the pulse rate indicated that this dilatation did not occur until after the man's visit to Dr. Trimble's office. The only diagnosis Dr. Randolph had ventured upon before death was failure of the right heart; thrombosis had been merely suggested as a possible cause. The infarct was not typical of cardiac thrombosis; the time of origin could only be determined by microscopic study.

Good for Medicine Men.—Admiral Dewey, on being complimented on his superb health, smiled and said: "I attribute my good condition to plenty of exercise and no banquets. One-third of what we eat, you know, enables us to live."

"In that case," said his friend, jestingly, "what becomes of the other two-thirds?"

"Oh," said the Admiral, "that enables the doctor to live."

A Good Excuse.—"Mrs. O'Rooney," said Father McMurphy, "why do I never see Patrick at church now?"

Mrs. O'Rooney shook her head sadly.

"Is it socialism?"

"Warse than thot, your riverence."

"Is it atheism?"

"Warse, your riverence."

"What is it, then?"

"Rheumatism."—*Exchange.*

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Editorial.

HISTORY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.—Price $1.00, with 25 cents added if delivered in this city or sent by mail. Address Dr. C. W. Franzoni, 605 I Street, N. W. The books are in the custody of Dr. D. S. Lamb, at the Army Medical Museum.

THE WASHINGTON MEDICAL ANNALS, the official organ of the Medical Society of the District of Columbia, issued the first of January, March, May, July, September and November, will publish gratuitously such information of a medical, surgical and sanitary character, changes in personnel, &c., of hospitals, dispensaries, medical schools, medical societies and other medical agencies, as would be useful and interesting to the members of the Society. Address the Chairman of the Committee on Publication, Dr. D. S. Lamb, 2114 Eighteenth St., N. W.

THE WASHINGTON MEDICAL ANNALS.—Back numbers.—Members of the Society who have back numbers of the ANNALS, and do not intend to preserve them, are requested to send them to the Chairman of the Publication Committee. Requests for such numbers are frequently received. Address Dr. D. S. Lamb, Army Medical Museum.

AMERICAN ASSOCIATION FOR THE STUDY AND PREVENTION OF INFANT MORTALITY.—The Sixth Annual Meeting will be held at the Bellevue-Stratford Hotel, Philadelphia, November 10 to 12. Dr. W. C. Woodward, Health Officer of the D. C., is First Vice President and will read a paper on "The statistical study of respiratory diseases." Among the Directors are the following: Dr. Carl L. Alsberg, of the Department of Agricul-

ture; Miss Julia C. Lathrop, of the Children's Bureau; Drs. J. W. Kerr and Schereschewsky, of the Public Health Service; Dr. Cressy L. Wilbur, of the Census Office, and Dr. Woodward. Dr. John L. Norris is chairman of one of the subcommittees. Among the affiliated societies in this city are the Columbia and Children's Alumnae Association, Graduate Nurses' Association of the D. C., and Instructive Visiting Nurse Society. For further information address Miss Gertrude B. Knipp, 1211 Cathedral Street, Baltimore, Md.

American Medical Editors' Association.—Annual meeting October 18 and 19 at the McAlpin Hotel, New York City. H. E. Lewis, President; Joseph MacDonald, Secretary and Treasurer, 92 William Street, New York City.

THE OTHER MEDICAL SOCIETIES OF THE DISTRICT OF COLUMBIA.

Alumni Medical Society of Georgetown University.—Active membership, 100; meets on the third Saturday of the month at the Medical School. Officers: J. A. Gannon, President; L. A. Martel and T. F. Lowe, Vice Presidents; C. I. Griffith, Recording Secretary; J. M. Moser, Corresponding Secretary; C. E. O'Connor, Treasurer.

Clinical Society.—Officers: F. L. Biscoe, President; W. J. Mallory, Vice President; E. P. Copeland, Secretary-Treasurer; Censors: L. A. Johnson and J. D. Thomas.

1915.	*Meeting Place.*	*Essayist.*	*Discussion by.*
October 12	J. D. Thomas	C. S. White	L. H. Reichelderfer.
November 9	E. P. Copeland	W. A. Wells	Dr. Richardson.

Clinico-Pathological Society.—Active membership limited to 25. Inactive membership: those who have withdrawn from active membership after fifteen years. A limited honorary membership of eminent medical men. Meets on the first and third Tuesdays of the month from October to May, inclusive. Officers: President, J. D. Thomas; Vice Presidents, Loren Johnson and H. P. Parker; Secretary and Treasurer, B. M. Randolph.

Freedmen's Hospital Medical Society.—Meets on the second Wednesday of each month from October to May, inclusive. Composed of physicians connected with the Staff of the Hospital and the Medical Faculty of Howard Medical School. E. A. Balloch, President; S. L. Carson, Vice President; C. A. Allen, Secretary-Treasurer.

GALEN SOCIETY of the District of Columbia.—Wm. H. Littlepage, President; Harry A. Ong, Secretary.

1915.	*Place.*	*Essayist.*
October 18	Dr. Pfender 304 Rhode Island Avenue, N. W.	Business Meeting. President's Address.
November 15	Dr. Henning The Rochambeau.	Dr. Pfender.
December 20	Dr. Titus 1730 M Street, N. W.	Clinical.

GEORGETOWN CLINICAL SOCIETY; twenty-five active members, limited to graduates of the Medical Department of Georgetown University. Meets at the University Club on the third Tuesday in the month. John Foote, President; J. Russell Verbrycke, Jr., Treasurer.

HIPPOCRATES SOCIETY, membership limited to 25, with voluntary retired members after 10 years, meets on the second Thursday of the month from October to May. Officers for the year: J. R. Verbrycke, Jr., President; C. A. Simpson, Secretary.

MEDICAL HISTORY CLUB of Washington, D. C.—Officers: President, Philip S. Roy; Vice-President, F. H. Garrison; Secretary, John Foote; Executive Committee, I. S. Stone, H. W. Lawson, Wm. A. White and the Officers. Members: Truman Abbe, Frank Baker, W. C. Borden, Joseph H. Bryan, G. Wythe Cook, John Foote, F. H. Garrison, Howard Hume, H. W. Lawson, W. J. Mallory, G. Brown Miller, J. D. Morgan, John B. Nichols, P. S. Roy, I. S. Stone, John D. Thomas, Wm. A. White, W. W. Wilkinson, Mathew Kollig.

MEDICAL AND SURGICAL SOCIETY of the District of Columbia.—President, John Dunlop; Vice President, H. H. Hazen; Secretary and Treasurer, L. Eliot; Asst. Secretary, L. C. Ecker; Executive Council, O. A. M. McKimmie, E. L. Morgan, L. Eliot, L. H. Reichelderfer and Ecker.

SOCIETY OF MEDICAL JURISPRUDENCE, Washington, D. C. —President, Dr. Wm. A. White; Vice President, R. Ross Perry; Secretary-Treasurer, Dr. D. P. Hickling. Meets on the second Monday of each month from October to June at University Club. Has from forty to fifty members.

SOCIETY OF OPHTHALMOLOGISTS AND OTOLOGISTS, Washington, D. C., meets the third Friday of each month from October until May, inclusive.

Officers: President, A. B. Bennett, Jr.; Vice President, A. H. Kimball; Secy.-Treasurer, Carl Henning, The Rochambeau.

Active members: A. B. Bennett, Jr., J. W. Burke, V. Dabney, W. T. Davis, L. S. Greene, C. M. Hammett, Carl Henning, E. B.

Jones, A. H. Kimball, R. S. Lamb, F. B. Loring, O. A. M. McKimmie, W. B. Mason, M. E. Miller, Mead Moore, S. B. Muncaster, W. S. Newell, J. J. Richardson, E. G. Seibert, R. R. Walker, W. A. Wells.

Inactive members: J. H. Bryan, W. K. Butler, H. S Dye, Wm. H. Fox, W. P. Malone, H. A. Polkinhorn, C. W. Richardson, D. K. Shute, W. H. Wilmer.

Schedule of Meetings—1915–1916.

	Residence of:	*Paper on Eye by:*	*Paper on Ear or Throat by:*
October	Dr. Henning	Dr. Lamb	Dr. McKimmie.
November	Dr. Mason	Dr. Loring	Dr. Wells.
December	Dr. Miller	Dr. Greene	Dr. Walker.
January	Dr. Loring	Dr. Muncaster	Dr. Miller.
February	Dr Richardson	Dr. Hammett	Dr. Moore.
March	Dr. Seibert	Dr. Newell	Dr. Richardson.
April	Dr. Hammett	Dr. Seibert	Dr. Jones.
May	Dr. Wells		Business meeting.

Society for Mental Hygiene, District of Columbia.—Organized at the New Willard June 3, 1915. Temporary President, Dr. Wm. A. White; temporary Secretary, Dr. D. P. Hickling. Organizing Committee: Surgeon General Rupert Blue, U. S. P. H. S., Miss Julia C. Lathrop, and Drs. White, Hickling and Frank Leech. The object of the Society is to work for the conservation of mental health, the prevention of mental disease and deficiency, and improvement in the care and treatment of those suffering from nervous and mental disease and mental deficiency.

Society of Social Hygiene, Washington, D. C.—President, Surgeon General Stokes, U. S. Navy; Secretary, Lt. Col. J. R. Kean, U. S. Army, Surgeon General's Office. The Society has four committees, namely: Education, Venereal Diseases, Protection of Women and Children, and Psychopathology. Yearly dues, $1.00. Persons desiring to become members should address Col. Kean and state to which committee they wish to be assigned.

Therapeutic Society of the District of Columbia.—Meets at the G. W. School of Pharmacy, 808 I Street, N. W., on the first Saturday in each month. G. W. Latimer, President; A. P. Tibbets, Secretary.

Walter Reed Medical Society meets on the fourth Thursday of every other month, from September to May inclusive. Composed of physicians located in the eastern part of Washington. Officers: J. S. Arnold, President; H. R. Schreiber, Vice President; M. H. Prosperi, Secretary; N. E. Webb, Treasurer.

Washington Medical and Surgical Society.—President, N. D. Graham; Vice President, R. R. Walker; Secretary, Walter Van Sweringen; Treasurer, F. E. Gibson; Curator

and Librarian, E. H. Egbert; Executive Committee: L. H. Taylor, Chairman, G. S. Clark, G. S. Barnhart; Program and Auditing Committee: Wm. A. Jack, Jr., Chairman, J. R. Nevitt, Walter Van Sweringen; Membership Committee: F. E. Gibson, Chairman, Wm. P. Reeves, Caryl Burbank.

Program—1915.

Essayist.	*Date and Host.*	*To open Discussion.*
President's Address	October 25, Dr. Emmons	Dr. Braden.
Dr. Taylor	November 22, Dr. Frankland	Dr. Burbank.
Dr. Van Sweringen	December 20, Dr. Gibson	Dr. Clark.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY.—President, J. F. Moran; Vice Presidents, G. B. Miller, Prentiss Willson; Secretary, Truman Abbe; Treasurer, D. W. Prentiss. Retired members—G. N. Acker, S. S. Adams, E. A. Balloch, J. W. Bovée, W. S. Bowen, W. P. Carr, G. Wythe Cook, M. F. Cuthbert, H. D. Fry, H. L. E. Johnson, J. T. Johnson, D. G. Lewis, A. R. Shands, E. E. Morse, Elmer Sothoron, J. Ford Thompson, John Van Rensselaer.

Program—1915.

Date.	*Essayist.*	*Reporters.*	*Host.*
October 8	J. F. Moran	President's Address Election of Officers.	Dr. Lowe.
November 12	S. L. Owens	Karl Corley R. Y. Sullivan.	Dr. Prentiss.
December 10	John Foote	L. A. Martel C. S. White.	Dr. Riggles.

WASHINGTON SOCIETY OF NERVOUS AND MENTAL DISEASES.—President, Wm. H. Hough; Vice President, Bernard Glueck; Secretary, J. J. Madigan. The Society has a limited membership of thirty, but welcomes Physicans and Surgeons interested in Neurology and Psychiatry. Meets monthly on the third Thursday at the Cosmos Club or a member's residence.

WOMEN'S MEDICAL SOCIETY of the District of Columbia.—President, Sophie Nordhoff-Jung; Vice President, Emma Lootz Erving; Secretary and Treasurer, Martha M. B. Lyon; Corresponding Secretary, Mary Holmes.

THE SECRETARIES of the other Medical Societies of this District are reminded that the ANNALS will publish the schedules of their meetings.

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS.—The following amendments have been made since the publication in Volume XII, March, 1913.

Constitution.—Article V, Section 4; adopted Nov. 4, 1914: before the words "Due notice" on page 142, insert "No application for membership that is rejected or withdrawn shall be renewed until after two years from the time of its rejection or withdrawal."

Section 10, same article; adopted Jan. 7, 1914: for "two years" substitute "one year."

Article VI, Section 5, adopted Jan. 6, 1915: in the last line, for "two" substitute "three."

Article VIII, Section 2, page 148, 4th line from top: for the word "disorders" substitute the word "diseases."

By-Laws.—Article VIII, Section 9, page 153: adopted Jan. 7, 1914: No member of the Staff of any hospital receiving patients in private rooms shall attend such private patient sent to the hospital by a member of the Society, not a member of the Staff, unless specifically requested to do so by the attending physician.

Please note that the figures in Sections 7 and 8 of this article, instead of being 7 and 8 should be 5 and 6.

Dr. T. A. Williams, 1705 N St., N. W., a committee on collecting instruments for Belgian Physicians, will be glad to receive any instruments that members of the Society can spare, however old such instruments may be. Kindly send to Dr. Williams or notify him that you can contribute them.

Belgian Scholarship Committee, Washington, D. C.—In consequence of the devastation of Belgian museums, libraries and universities, numerous worthy students, research workers and professors, many of them crippled for life, are interrupted in their important work. To the lovers of equity and to those who cherish education and admire Belgian integrity and heroism an opportunity is hereby given to assist in bringing to America worthy intellectual men and women for a temporary free enjoyment of the privileges of American institutions.

This committee has already received assurances from the George Washington University for the instruction of ten students in any of the departments of the University. It is highly probable that the committee will receive from other American institutions similar assurances.

It is proposed to raise a fund at once to defray the traveling expenses to and from Belgium and the cost of residence in Washington for a period of one year of the students or research workers which the George Washington University has already generously provided for. In the case of professors it is hoped that the subscriptions will be sufficiently liberal to provide for honorariums as well, thereby giving all the students in Washington the benefits of lectures by Belgian scholars.

It is estimated that from $20,000 to $25,000 will be needed in the work at once, and in the event of a surplus being accumulated, it is proposed to apply this to the recuperation of educational work in Belgium. This committee is a subcommittee of the Central Committee for the Belgian Relief Fund for Women and Children and other noncombatants, and it is organized with the

approval of his Excellency, the Minister from Belgium to the United States.

Please draw checks payable to Belgian Scholarship Committee, John Joy Edson, Treasurer, Washington Loan and Trust Building, Washington, D. C. Checks for any amount, large or small, are earnestly asked for.

Belgian Relief.—George W. Crile, of Cleveland, says: "When I was in Belgium I received first-hand information from a number of Belgian physicians concerning their plight. They are indeed in dire need, and there seems to be no way by which this need can be overcome until their land is restored to them again. The free masonry of the medical profession so binds all medical men together that it seems to me that no appeal to doctors for the aid of their associates in Belgium can be in vain. We should all realize also that no single appeal can satisfy what is going to be a long continued need; that we must give now, later again, and still later, and so answer repeated appeals until later conditions may restore to the Belgians the wherewithal to aid themselves."

Dr. J. Riddle Goffe, of New York, says that in a letter just received from Dr. Jacobs, of Brussels, the latter summarizes the situation of our Belgian colleagues as follows:

1. Many doctors were killed, consequently the widows and orphans, deprived of everything, are without a home, without means, with nothing left. 2. All country doctors or those living in small towns are ruined by loss of every possession they had. 3. Doctors in large cities are ruined by commandeering, war levies, etc. 4. The largest part of Belgian population has become the prey of infectious diseases, epidemics, with a large infant mortality, etc. 6. Ruined civilian populations cannot pay for medical advice, consequently several physicians are compelled to work for nothing, others are obliged to undertake any labor for gain as a means of livelihood with results that are terrible for the population.

The opportunity is here created for the medical profession of the world to show the brotherly feeling which exists among them, and they can do this by helping with the necessary funds.

Gorgas Prize Medal.—To be awarded yearly for the paper which shows the most important advances in medicine or surgery, on a medical or medico-military subject, preference being given to papers on medico-military subjects. Only for papers of exceptionable value. Competition is open to medical officers of the Army, Medical Reserve Corps of the Army, and medical officers of the organized militia. The prize is given by the Association of the Medical Reserve Corps, U. S. Army, New York State Division. The Board of Award consists of three members of the Faculty of the Army Medical School appointed by the Surgeon General of the Army. The papers to be submitted by

March 31st of each year, to the President of the Board of Award, Gorgas Prize Medal, Army Medical School, Washington. The award to be announced at the graduation exercises of the School May 31st.

FRATERNITAS MEDICORUM.—The Medical Brotherhood for the Furtherance of International Morality. (See *Science*, August 6, page 179.) Every physician may become a member; man or woman; no fee required, but in order to maintain the organization, distribute literature, &c., voluntary contributions are welcome. President, Dr. S. J. Meltzer, Rockefeller Institute, New York City. The first Secretary is Dr. Wm. J. Gies, Columbia University, New York; Treasurer, Dr. Robert T. Morris, Post Graduate Medical School. There are a number of Councillors, all of them well known physicians. Also a large number of Honorary Presidents, of whom the following are Washingtonians: Surgeon General Gorgas; Dr. Alice Hamilton of the Federal Bureau of Labor Statistics. Also an Advisory Committee, including Dr. Alsberg of the Bureau of Chemistry, Dept. Agriculture, Dr. Anderson of the Hygienic Laboratory and Dr. Garrison of the Surgeon General's Library.

A committee of physicians and medical investigators request every physician to enroll as a member and declare his or her willingness to endorse and support the moral standard which the medical profession upholds when called on to perform its patriotic duties in an international strife. All communications should be addressed to Dr. Meltzer, 13 West 121st Street, New York City.

THE ASSOCIATION OF MILITARY SURGEONS will meet in Washington September 13 to 15.

SIBLEY MEMORIAL HOSPITAL, located at North Capitol and Pierce Streets, has completed the installation of an up-to-date Roentgen ray laboratory. The department occupies four rooms on the fifth floor of Robinson Hall, and contains the most modern apparatus available for fluoroscopy, radiography and deep therapy by x-rays. Dr. Charles A. Pfender has been appointed Roentgenologist in charge.

RECENT PUBLICATIONS BY PHYSICIANS OF THE DISTRICT OF COLUMBIA.

C. L. Alsberg and O. F. Black; Distribution of cyanogen in grasses; *Jour. Biol. Chem.*, July.

J. F. Anderson; Alleged relation between vaccine virus and postvaccination tetanus; *Jour. A. M. A.*, July 10, page 194. Also, The laboratory diagnosis of bubonic plague; *Amer. Jour.*

Pub. Hlth., February, page 147; abstracted in *South. Med. Jour.*, July, page 636. Also, Laboratory methods in diagnosis of typhus; *Amer. Jour. Pub. Hlth.*, May.

W. H. Atkinson; Tetanus following an operation for hemorrhoids; *Va. Med. Semi-Mo.*, July 23, page 187.

E. A. Balloch; Case of papillomatous cyst of nipple; WASH. MED. ANNALS, May, page 158; abstracted in *Jour. Med. Soc. New Jersey*, July, page 337.

C. Bates; Sanitary control of shellfish industries; *Amer. Jour. Pub. Hlth.*, May.

J. W. Bovée; Use of galvano-cautery knife for excision of mammary tumors for microscopic diagnosis; *Amer. Jour. Obstet.*, July.

J. G. B. Bulloch; Some proof why we require many medicinal drugs; *Western Med. Times*, Aug., page 51. Also, List of drugs which are necessary to practice medicine; same journal, July, page 1.

W. M. Clark; Reaction of bacteriologic culture media; *Jour. Infect. Dis.*, July.

W. M. Clark and H. A. Lubs; Differentiation of bacteria of colon aerogenes family by use of indicators; *Ibid.*

R. H. Creel; The migratory habits of rats with special reference to the spread of plague; reprint 278 from Public Hlth. Reports, June 14.

V. Dabney; Idiopathic mastoid abscess; *Jour. A. M. A.*, Aug. 7, page 501.

A. M. Fauntleroy; Shock, anoci association and anesthesia; *Va. Med. Semi-Mo.*, Aug. 13, page 209. Also, Surgical diagnosis and technique involving the appendix; U. S. Naval Med. Bull., July, page 381.

H. A. Fowler; Clinical types of prostatic obstruction and their surgical treatment; *Sur. Gynec. and Obstet.*, August.

Carroll Fox; Public Health in Toledo; reprint 284 from Public Health Reports, June 25.

B. H. Frayser and D. O. Smith; Pellagra in Panama; *South. Med. Jour.*, August.

F. H. Garrison; John Shaw Billings; Review in *Amer. Jour. Surgery*, August, page 316.

Joseph Goldberger, C. H. Earing and D. G. Willets; The treatment and prevention of pellagra; Pub. Hlth. Reports, October 23, 1914; abstracted in *South. Med. Jour.*, July, page 636.

W. C. Gorgas; Sanitation in Panama; 298 pages; illustrated; price $2.00, net; New York; Appleton & Co. Reviewed in *Jour. A. M. A.*, July 17, page 273.

F. R. Hagner; Bulgarian bacillus in treatment of cystitis and pyelitis with alkaline urine; *Surg. Gynec. and Obstet.* July. [See *Jour. A. M. A.*, Jan. 30, page 465.]

W. H. Hazen; Roentgen ray therapy in large measured doses; *Va. Med. Semi-Mo.*, Aug. 13, page 225. Also, Cancer of skin;

abstracted in *Jour. Med. Soc. New Jersey*, July, page 353. Also, The pathology and treatment of cutaneous cancer; *South. Med. Jour.*, July, page 577.

V. G. Heiser; Recent experiences in the orient with chenopodium as remedy against hookworm and other intestinal parasites; *Jour. A. M. A.*, Aug. 7, page 526.

M. J. Jones; Popular education in mouth hygiene; *Amer. Jour. Pub. Hlth.*, May.

S. R. Karpeles; The early diagnosis of cancer; *Va. Med. Semi-Mo.*, July 9, page 160.

R. S. Lamb; Case of gonorrhoeal iritis following traumatism; *Ophthal. Record*, July. Also, Subconjunctival injections of salvarsanized serum in the treatment of ocular diseases due to syphilis; WASH. MED. ANNALS, March, page 69; abstracted in *West Va. Med. Jour.*, July, page 33.

R. E. Ledbetter; Case of fracture dislocation of spine; laminectomy; *U. S. Naval Med. Bull.*, July, page 433.

M. R. Lewis; Rythmical contraction of skeletal muscle tissue observed in tissue cultures; *Amer. Jour. Physiology*, July.

Wm. Lyster; Vaccination against typhoid in U. S. Army; *Jour. A. M. A.*, Aug. 7, page 510.

E. P. Magruder; Letter from Serbia; *Amer. Jour. Surgery*, August, page 310.

W. J. Mallory; The present status of the diagnosis of cancer of the stomach; *Med. Record, N. Y.*, June 26.

H. A. May; Sanitary notes from U. S. S. Washington; *U. S. Naval Med. Bull.*, July, page 537.

Medical and Surgical Society D. C.; Transactions; *Va. Med. Semi-Mo.*, July 23, page 202, and August 13, page 226.

J. M. Moser; Observations on the treatment of tetanus; *Ibid.*, page 219.

J. A. A. L. Prince; Impounded waters; Public Hlth. Reports, Feb. 12, page 473; abstracted in *South. Med. Jour.*, July, page 635.

L. H. Reichelderfer; Unusual case of foreign body in appendix; WASH. MED. ANNALS, May, page 154; abstracted in *Jour. A. M. A.*, Aug. 7, page 559.

E. W. Reisinger; Sanitation *vs.* typhoid vaccination; *Va. Med. Semi-Mo.*, Aug. 13, page 215.

W. F. Rice; Some difficulties in diagnosis of general paralysis of insane; *Med. Record, N. Y.*, July 17.

C. W. Richardson; Tonsillectomy in the adult; are we justified in doing so many indiscriminate tonsillectomies for remote infection; *Laryngoscope*, May.

L. A. Rogers, W. M. Clark and A. C. Evans; Characteristics of bacteria of colon type occurring on grains; *Jour. Infect. Dis.*, July.

W. C. Rucker; Note on a rodent plague focus; Reprint 281

from Pub. Hlth. Reports, June 11. Also, Address to be delivered over the body of a young man dead of typhoid fever; *Calif. State Jour. Med.*, July, page 288.

W. Salant and A. E. Livingston; Influence of oil of chenopodium on the circulation and respiration; *Amer. Jour. Physiology*, July; abstracted in *Jour A. M. A.*, July 24, page 359.

C. A. Simpson; The cause, prevention and cure of falling hair; *Hospital News*, June, page 5.

D. O. Smith; Pellagra in Panama; *South. Med. Jour.*, August, page 678.

F. C. Smith; Exercise and health; Supplement 24 to Pub. Hlth. Reports, May 7.

C. W. Stiles; Zoöparasitic intestinal infections; Reprint 286 from Pub. Hlth. Reports, July 2.

Edgar Thompson; A possible new x-ray sign of tuberculosis; *U. S. Naval Med. Bull.*, July, page 436.

J. W. Trask; Statistics of disease; *Amer. Jour. Pub. Hlth.*, May. Also, The practicing physician; his relation to public health administration; Reprint 280 from Pub. Hlth. Reports, June 11.

H. W. Wiley; Importance of mouth hygiene to general health; *Amer. Jour. Pub. Hlth.*, May.

A. W. Williams; Report of surgical service at Field Hospital, Company No. 3, Texas City, Texas; *Mil. Surgeon*, Dec., 1914; abstracted in *South. Med. Jour.*, August, page 713.

T. A. Williams; The management of functional nervous affections; modern methods illustrated; *South. Med. Jour.*, July, page 616. Also, Cause of arterial hypertension, with report of the treatment; *Lancet-Clinic*, June 5. Also, Compensation of workmen and others for neurosis following accident; *New Orleans Med. and Surg. Jour.*, June 5. Also, Occupation cramp, its nature and treatment; *West. Med. Times*, August, page 54. Also, Treatment of epilepsy from metabolic disturbances in adolescence; *Med. Record, N. Y.*, May 8; abstracted in *Nat. Med. Assn. Jour.*, July-September, page 221. Also, Misdiagnosed cases of compression of spinal cord; *Va, Med. Semi-Mo.*, May 7, page 60; abstracted in *Florida Med. Assn. Jour.*, May 1. Also, Prevention of suicide; *Amer. Jour. Insanity*, January; abstracted in *Old Dom. Jour. Med. and Surgery*, August, page 87.

PERSONAL NOTES.

Dr. W. H. Arthur, Colonel, M. C., U. S. A., has been ordered to duty as commandant of the Army Medical School.

Mrs. Virginia Johnston Bulkley, widow of Dr. John Wells Bulkley (who for many years was a member of this Society) and

mother of Barry Bulkley and Robert Wells Bulkley, died in this city August 9.

Dr. John Lewis Riggles was married June 30 to Miss Caroline Naomi Honodel.

Dr. C. R. Dufour read a paper before the Medical Society of Grant, Hampshire, Mineral and Hardy counties, at Moorefield, West Va.

Mrs. Mary John Llewellin Eliot, widow of Dr. Johnson Eliot and mother of Mrs. McNally and Drs. Llewellin and Johnson Eliot, Jr., died July 2 at her home in this city. Mrs. McNally is the widow of Dr. Valentine McNally, who was also a Major in the Ordnance Corps of the Army. All of the medical men named were members of this Society, and Drs. Llewellin and Johnson Eliot, Jr., are still members. The senior Dr. Eliot was quite a prominent practitioner in this city, doing mainly surgical work. His biographical sketch and portrait are in the History of the Society.

Dr. M. B. Fischer was married June 22 to Miss Marguerite Greenhut, of Escanaba, Mich.

Drs. E. A. Gendreau, F. D. Gibbs and F. M. Harrison, recommended for admission to Navy Med. Res. Corps.

Dr. Henry Gray, graduate of the College of Physicians and Surgeons, N. Y. City, 1867, a Major in the Union army during the civil war, and for 45 years a member of the Greenwich, N. Y., Board of Education, died at Greenwich, June 20, age 73. It is stated on page 285 of the History of this Medical Society that Dr. Gray died between 1867 and 1870. Of course this statement is an error. Dr. Gray was elected a member of this Society May 29, 1867, and there does not appear to be any further record of him. He was elected a member of the Medical Association July 17, 1867, and signed the constitution some time before October 2. There is no further record except the death note as above incorrectly stated.

Dr. P. F. Harvey, Colonel, M. C., U. S. A., retired, was married June 22 to Mrs. Kathryn Patterson Talmadge.

Dr. H. H. Johnson, Captain, M. C., U. S. A., has been transferred from the Walter Reed Hospital to duty at Fort Bliss, Texas.

Dr. H. L. E. Johnson was elected Vice President of the Pan American Medical Congress at the meeting in June at San Francisco.

Dr. Louise Tayler-Jones has gone to Serbia to organize, it is said, a hospital for babies; to return to Washington in October.

Drs. J. J. Kinyoun and E. B. Vedder attended the meeting of the Amer. Assn. of Immunologists in this city May 10, and took part in the discussions.

Dr. R. S. Lamb attended the meeting of the Colorado Ophthalmological Congress July 22 and 23 at Denver, and read a

paper on "Is migraine a forerunner of glaucoma." Dr. Lamb also read a paper before the Amer. Ophthal. Society at New London, Conn., in July.

Dr. T. J. Leary, Captain, M. C., U. S. A., has been relieved from duty at the Walter Reed Hospital.

Mrs. Mary Mulcahy, mother of Dr. D. D. Mulcahy, died July 16.

Dr. E. L. Munson, Lieut. Col., M. C., U. S. A., ordered to duty in Surgeon General's Office.

Dr. W. F. R. Phillips of this Society has been appointed Professor of Anatomy at the Medical College of South Carolina.

Drs. H. C. Pillsbury, Captain, M. C., U. S. A., and Wm. F. Rice of Med. Res. Corps, U. S. A., have been ordered to duty at the Walter Reed Hospital.

Dr. Charles Richard, Colonel, M. C., U. S. A., has been transferred to San Francisco, as surgeon of the Western Department.

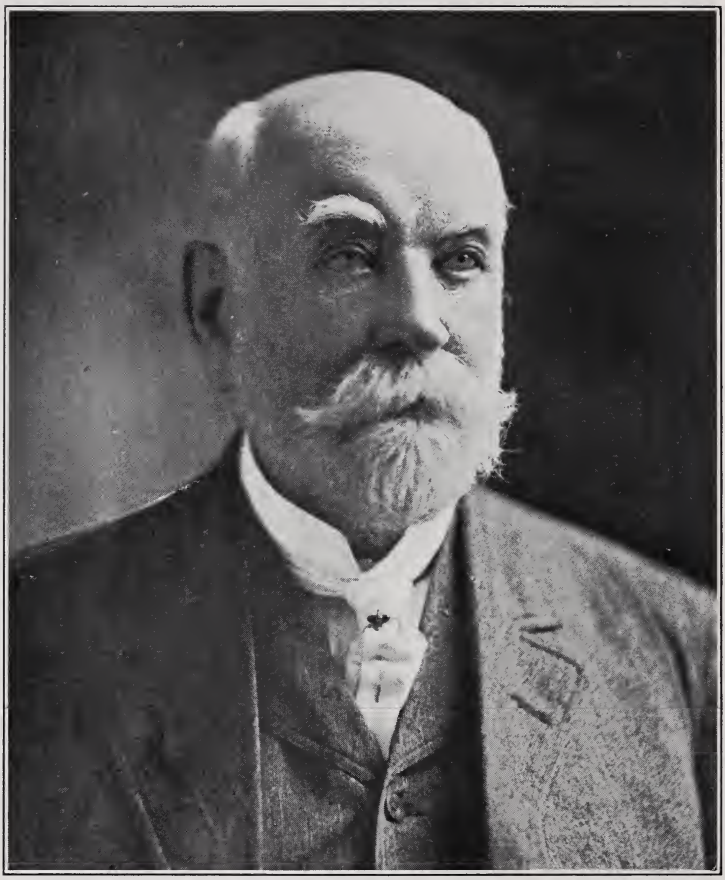
Dr. W. H. Slaughter transferred from Ellis Island, N. Y. Harbor, to Hygienic Laboratory.

Dr. French Simpson transferred from Hygienic Laboratory to New Orleans.

Dr. Elmer Sothoron was married August 11 to Mary Edna Tulley, of Philadelphia.

Dr. E. M. Talbott, Captain, M. C., U. S. A., has been transferred from this city to Philadelphia.

Dr. W. H. Wilmer was elected a councillor at the annual meeting of the Amer. Ophthal. Society at New London, Conn., July 6 and 7.



DR. WARWICK EVANS.

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SCARLET FEVER—MORBIDITY AND FATALITY. ABSTRACT.*

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Washington, D. C.

Variations in susceptibility to scarlet fever in individuals and in families are seen by physicians in active practice in contagious disease hospitals and otherwise. A study of large numbers of cases in various communities and countries was made in the study of this and kindred questions, use being made of board of health statistics. Scarlet fever, of all reportable diseases, lends itself best to such a study. Morbidity and mortality rates were calculated by means of the number of inhabitants, the number of cases of scarlet fever, and the number of deaths reported by physicians.

Over 7,000,000 cases were collected and studied from communities in America, Europe and elsewhere.

The disease was found to possess a genius of locality, for wide variation in the amount of scarlet fever in one community as compared with another was found, also mortality was high in some communities as compared with others where it was much lower.

From the beginning of notification to the present, in all of the communities studied, curves of morbidity and mortality were plotted. No periodicity in the occurrence of scarlet fever epidemics was made out. As far as morbidity rates establish the fact, scarlet fever is nearly as prevalent now as forty or fifty years ago. In Norway, where highly reliable statistics may be obtained and where reporting has long been a requirement, a fall in the amount of scarlet fever was ascertained. The most striking fact about case-fatality of scarlet fever in the past half century has been its consistent, general and marked reduction. Several reasons were offered in explanation of the lowered fatality. Wide variation in virulence of epidemics was shown by figures. Season, as such, exerts no influence. The sexes as a whole show about equal susceptibility. During the first five years of life males are more susceptible to the disease, while between five and fifteen years females are distinctly more susceptible. Case-fatality is higher

* Read before the Medical Society October 6, 1915.

among males at all ages. Nearly half of the scarlet fever cases was found to occur in the five years between three and eight years of age distributed nearly equally in each of the five years, and two children out of three at this age contract the disease, when exposed to it in their homes. Ninety per cent. of cases occur under fifteen years of age. Mortality is highest in infancy, being from 12 to 20 per cent.; lowest at about ten years of age, and thereafter gradually increases with age. About 90 per cent. of deaths occur under ten years of age.*

Dr. Woodward was sure that he voiced the feeling of the entire audience when he expressed his great appreciation of the paper. The amount of labor incident to the compilation of the statistics Dr. Donnally had presented, based on such an enormous number of cases, can hardly be conceived by those not familiar with statistical work. He was sorry that Dr. Donnally did not present death rates on the same basis as the case rates, but he told Dr. Woodward that there were good and sufficient reasons for omitting them. Dr. Woodward had been interested in looking over some of the figures of record in the Health Department showing the prevalence of scarlet fever in the District of Columbia. In 1885, the death rate from scarlet fever was 53 per 100,000. What the conditions were that occasioned such high mortality he did not know, but at no time since 1885 had the death rate exceeded 14 per 100,000. The passage of the compulsory reporting law apparently reduced the death rate. Prior to the law, and beginning in 1885, the deaths from scarlet fever ran as follows: 53, 11, 8, 9, 14 per 100,000. In 1890 the law was enacted that required all cases of scarlet fever to be reported and provided for their isolation, and since that time, beginning with 1891, the death rates had run as follows: 4, 8, 4, 7, 10, 2, 1, 6, 9, 4, 4, 2, 1, 3, 3, 2, 1, 3, 8, 3, 1, 1, and 4; and in 1914 the death rate fell to 0.3. Case rates prior to the enactment of the law were, of course, unknown. That scarlet fever moved in waves was well shown by the graphs prepared by Dr. Donnally; in every community there appeared years in which the incidence of scarlet fever was high, followed by a year or two in which its incidence was low, a year of high incidence then occurring again. This, of course, was accounted for by the varying susceptibility of the population taken as a whole. In a year of high scarlet fever incidence a large part of the then susceptible population was attacked and thus became immune. As a result there followed two or three years of low incidence during which the non-immune population was increasing, and when it became sufficiently large, another high wave of the disease occurred, and so the process was indefinitely repeated. The greatest difficulty in all statistical studies was the drawing

* These facts were brought out graphically by means of lantern slides.

of conclusions of practical value, and that we are hardly prepared to do from the studies that had been presented by Dr. Donnally. Dr. Woodward hoped very much that Dr. Donnally would pursue this subject further, inquire into varying conditions of life, laws, regulations, administration, customs and habits prevailing in the different localities from which his figures had been drawn, at the different periods covered by his paper, until he could point out the reasons for the fluctuations in the morbidity rates and case fatality that he had reported, and show us how both may be reduced.

Dr. Nichols said that conclusions like those drawn by Dr. Donnally on a basis of over 7,000,000 cases must represent nearly the last word on the subject. The slight but constant relative excess of the male mortality and to a certain extent the male morbidity from scarlet fever as compared with the female, brought out by Dr. Donnally's statistics, is an exemplification of the well-established fact that the resistance of the male organism to disease influences is definitely less at all periods of life than that of the female.

Dr. M. F. Thompson wished to commend this admirable paper and to recognize its great value. Any study of scarlet fever should be of value to the practitioner because every medical man of any experience meets with this disease. There can be no doubt that it is a house disease; a family may have scarlet fever in a certain house, that family moves out, the next family has scarlet fever, after it another family moves in; scarlet fever all over again. The children running around such a house distribute the infectious scales all over the place and thus the disease is preserved in the house. The statement was made that scarlet fever is a readily diagnosed disease. Who made that assertion? He believed that scarlet fever was one of the most difficult of diseases to diagnose with any certainty in obscure cases; if we doubt that, ask the Health Department inspectors if it is easy to recognize. When he started to practice medicine in 1884, there was a serious epidemic of scarlet fever; everybody said, "You'd better keep out of medical work; scarlet fever will be the end of you." Since then he had treated scarlet fever every year and had had only two deaths from that disease. This record had not been due to superior treatment. Perhaps the general tendency toward better ventilation may account for the gradually declining mortality rate.

Dr. J. S. Wall said that the paper had opened a very wide field for discussion. Perhaps one of the most interesting features is the gradually converging curves for mortality and morbidity. Why has this decline in mortality taken place? We know of no greatly improved mode of treatment to account for it; perhaps just such studies of the statistics of the disease may point the way for the determination of just such problems. Increasing racial immunity

may be an important factor in the decline of the mortality of this disease. He wished there might be made a similar study of the so-called minor contagious diseases—say, whooping cough ; perhaps the needed public interest might be awakened.

Dr. Masterson asked if Dr. Donnally had come to any conclusion as to the contagiousness of scarlet fever scales? Many authorities now hold that the scales are not contagious, and the practice in many English communities is to dismiss scarlet fever cases from quarantine regardless of the stage of desquamation as soon as the nose, throat and ears are clear. The average quarantine for scarlet fever is 29 days, regardless of the scales.

Dr. Frank Leech had a particular interest in this subject because he had had charge of the contagious wards at the Garfield Hospital for the past two years and thus has had a large number of cases under his care. He had recently had tabulated all cases treated in those wards during the year ending September 1, 1915; there were 220 cases, with 3 deaths. All the deaths occurred in males over fifteen years of age. These cases represent about one fourth of the cases in the District of Columbia in that period. It may thus be seen that the factor of hospital treatment has not materially influenced the mortality of the disease in this locality. Questions as to infectiousness, desquamation and so on were not in the scope of the paper.

Dr. H. H. Donnally had hesitated somewhat about presenting the paper because of the difficulty of making a statistical study very interesting. Some striking facts were brought out, indicating a growing mildness of the disease, with little reduction in amount; but the figures in the main support our common beliefs about scarlet fever. So far as seasonal variations are concerned, the figures indicate that no rule can be laid down. The peculiar genius of locality of scarlet fever invites an intensive study in various communities. An interesting feature is the uniform persistence, throughout all tables and curves, of the sex variation for morbidity and the age incidence of the disease.

In preaching the minister had been rather long winded, when the young bride remembered that she had left the dinner in the gas range without regulating the flame. She hastily wrote a note and slipped it to her husband, who was an usher. He, thinking it was intended for the minister, calmly walked up and laid it on the pulpit.

The minister paused in the midst of his sermon and took the note with a smile, which changed into a terrible frown as he read :

"Please hurry home and shut off the gas."

A CASE OF HEREDITARY SYPHILIS.*

By Captain Mathew A. Reasoner,

Medical Corps, U. S. Army.

On May 24, 1915, Mrs. A. B. was referred to me for examination and treatment. The history obtained at that time was as follows: Age 31; family history negative; married at the age of seventeen to a syphilitic husband. Became pregnant at the end of the first month and had a miscarriage at the end of the seventh month. Five months afterward she became pregnant again and at full term was delivered of an apparently healthy child of normal appearance and weight. Following this, the mother became anemic and very much depleted in weight and strength. After several years she developed a lesion of the clavicle and one of the tibia, and later on, another apparently involving the antrum of Highmore, which lesions persisted either continuously or recurrently for several years. In 1912, her condition was recognized for the first time, and upon receiving anti-syphilitic treatment, she promptly reacted in a fairly satisfactory manner. The lesion involving the left superior maxilla still persists. The Wassermann reaction on May 24, 1915, was double plus (complete inhibition) down to 0.0125 titration. Since that time it has shown no reduction in spite of several months rather vigorous mercurial treatment. No abnormalities of the circulatory or nervous systems could be determined which could be ascribed to this condition. Dr. Louis Green very kindly examined her eyes and reported the findings negative.

I asked the mother to bring her little girl to me for examination, but she demurred, stating that the child was in perfect health and always had been and several physicians had told her that it was not possible that anything might be wrong with the child. On June 18, 1915, or less than a month after my request, the mother brought the child on account of her eyes. I found her to be a remarkably well formed girl thirteen years of age, five feet, one and one fourth inches in height, and weighing 105 pounds. When it is recalled that she is superior to the average girl or boy of thirteen years and the standard medium type boy of fourteen is only five feet, two and one-half inches in height and weighs 95 pounds, it will be seen that physically this girl is above the average. Her mentality is that of the average girl of fifteen or sixteen years.

No stigmata or marks of degeneration or congenital syphilis could be found and with the exception of the eye condition, she presented the appearance of health and vigorous childhood; and according to her mother, has been so since birth. She has had no illness except measles and pertussis. She is in the eighth

* Reported to the Medical Society, October 6, 1915.

grade and has always stood at the head of her class. I was unable to determine evidences of mental irritability or unstable disposition. Wassermann reaction double plus.

Upon examination there was found a well marked case of keratitis of the left eye, with beginning inflammation of the right eye. The mother stated that it had existed for about eight days. The patient was given 0.2 gm. salvarsan and an injection of mercury, and sent to Dr. Louis Green for further examination and local treatment. Dr. Green reports as follows: "At the time of the first examination, the left eye showed a typical interstitial keratitis, the salmon patch being particularly large, situated just below the center of the cornea, and filled with exudate. Iris swollen and muddy. Vision reduced to counting fingers. The right eye at this examination was just beginning to show involvement, the lower segment of the cornea showing haziness. Vision still 20/20. Local treatment of atropia and hot water only.

At the end of three days there was a decided improvement in the left eye and it continued to progress rapidly until at the end of a month the vision had become 20/30, and the cornea was free from opacities except at the site of the salmon patch below the center of the cornea, where the corneal microscope showed some infiltration.

The involvement of the right eye progressed until vision was reduced to 10/200 at the height of the inflammation, but at no time was the inflammation so acute nor did the salmon patch appear. In two weeks following the fastigium the vision in this eye had again reached 20/20." Dr. Green further states: "I have never seen so severe a case of keratitis yield so readily to treatment nor leave behind less injury to the tissues involved."

This case is not presented for the reason that it involves any new methods in the treatment of syphilis, as the ordinary combined intensive method of treatment was used. I do, however, think that the following points deserve to be emphasized.

1. A congenitally syphilitic child reaches the age of thirteen years without physical manifestations and during this time is both mentally and physically superior to the average child of her age. Before the onset of the keratitis and without a knowledge of her family history, I doubt if there is one of us who would have from physical examination of the girl, suspicioned the presence of congenital syphilis. In fact it would have required more than one double plus Wassermann reaction to convince the writer.

2. After thirteen years and without any discoverable cause, such as trauma, heat, cold, fever or other illness, an explosion takes place and a most acute process supervenes.

3. This long delayed process in a congenital syphilitic, shows itself remarkably amenable to treatment.

4. It would seem that in this patient, the wisdom of giving salvarsan at the first was well justified by the results.

5. In spite of four and one-half months' vigorous treatment and satisfactory results so far as the manifest lesions are concerned, the Wassermann reaction still remains double plus (complete inhibition). As to what will be the final outcome time alone can tell. Certainly this little girl deserves all that can be done to better enable her to bear the heavy burden of which she is the innocent sufferer.

Dr. Hough said that this case was most interesting and instructive. It reminded him of certain congenital syphilitic affections of the nervous system and it was interesting to note that the eye may be regarded as a prolongation of the central nervous system. Congenital syphilis of the nervous system is very apt to break out about puberty, as was the case in this instance. It may first appear later, however ; La Fora had two cases, one at 26 and one at 28 years of age ; there is another case on record in which the disease appeared at 31 years of age. This case shows very clearly the importance of intensive treatment.

Dr. Kober said that the case was of special interest in view of the findings of Warthin of the University of Michigan that family syphilis is as prevalent and as dangerous as tuberculosis. Dr. Kober had frequently called attention to the fact that the case incidence of syphilis in the United states Army is higher than in any other army of the world ; the disease is not contracted in the barracks but in the communities where the men are stationed. The high still-birth rate in this District is very suggestive in view of the influence of syphilis in the causation of still births; it serves to indicate the importance of the prenatal examination of pregnant women, including the Wassermann test, with the view of instituting timely treatment.

Dr. S. S. Adams asked Dr. Reasoner whether the father of this child went crazy? Dr. Adams asked the question because he had under his care for a while a man and wife who came to this city from Boston ; they brought a note from a Boston physician which stated that the father was luetic ; that the wife had contracted the disease, had had a still-birth, and later a girl child ; this child Dr. Adams kept under observation while the family lived in Washington. After moving away, the father went insane ; he confessed to his wife that he was syphilitic and that he had infected her. She came to Dr. Adams and told the story and asked if he had known anything about the syphilitic history of her husband ; Dr. Adams told her that he had been informed of it by their Boston physician. She vigorously expressed her indignation at Dr. Adams' silence about the matter and left the office, and he had heard nothing of the family since.

Capt. Reasoner was unable to give any history of the father as he was not in the city. He did not, however, develop nervous manifestations. Dr. Reasoner thought it quite probable that, as Dr. Hough had suggested, the element of puberty is a determin-

ing factor in the appearance of the manifestations at this time. He agreed with Dr. Kober in the necessity for the "ounce of prevention" in the protection of the innocent unborn. Proper and adequate treatment of the mother, or better, the father primarily might have saved this little girl from a terrible misfortune. As regards the case incidence of syphilis in the United States Army, it is very true that the statistics do show a relatively high rate as compared with European armies. It must be remembered, however, that in our army every case of venereal disease is made a matter of record whether on sick report or not, and under our methods of inspection it is rather rare for a venereal disease to pass without detection. Such is not the case in the continental armies and hence the apparent disparity in the occurrence of the disease.

EVOLUTION OF MAN IN THE LIGHT OF RECENT DISCOVERIES AND ITS RELATION TO MEDICINE.*

By Ales Hrdlicka, M. D., Curator of Physical Anthropology, U. S. National Museum,

Washington, D. C.

Human evolution is no more a mere theory or even as in Darwin's time a wonderful scientific deduction, but rather a fixed part of natural history, day by day better documented by substantial evidence.

Its foundations rest upon many and important organic analogies; on actual physical remains of early man and perhaps even some of his predecessors, and on observations of the changes which are actually taking place in man.

The *analogies* are:

(1) The evidence of evolution in all the better known mammals;

(2) The relation of various stages of the embryonic development of man to grades of life represented by some lower vertebrates;

(3) Those of the mode of conception, of the laws of development, of all other vital functions, and in death;

(4) Physical similarities to identities in organs, limbs and all other physical as well as microscopic parts of the human body;

(5) Close similarities to identities of the chemical constituents of the human body with those of other mammals; and

(6) The frequent presence in man of vestiges of or reversions to anatomical features still regularly present in some lower animals.

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* Read before the Medical and Anthropological Societies, at a joint meeting, October 13, 1915.

The *physical evidence* of man's evolution consists of a large series of skeletal remains dating from early Pleistocene to the last prehistoric period. These remains show in general that the farther back we proceed the more primitive were the human features and the nearer to those of the lower primates. This evidence alone is quite conclusive; there are, of course, as yet many important gaps in the line of this evidence, especially relating to the earlier periods, which, however, are gradually being filled in.

The historical and actual changes in man show us that his evolution has not as yet been fully accomplished, but is still progressing, and that possibly among the civilized white men, it is progressing more rapidly than it has during most of its course. We see that the higher civilized white man has already in some respects outdistanced others, that he is rapidly diversifying, and that all about us those who cannot keep the accelerated pace are being eliminated by nature. Probably the most obvious changes are taking place in his teeth, which are gradually lessening in resistance, in size, and even in numbers; changes which in turn, condition weakening and numerous disharmonies in the whole facial structure. Loss of hair is another example.

The process of human evolution has close *relation to medicine;* much closer in fact than commonly appreciated by even the surgeon and physician. Evolution is not only constructive but eliminative, involving weakening, degeneration, and eventual loss of parts which have become less useful, less functional. The progressive and retrogressive changes are not always harmonious or generally beneficial to the individual, and bring about many conditions which demand medical or surgical intervention.

The process of evolution bears, however, still older relations to medicine. It has prolonged the periods of infancy, childhood and senility in man, the most dangerous periods of an organism; the assumption of the erect posture had necessarily adverse consequences on the circulatory system which probably have not yet been completely overcome, and in seriously modifying the abdominal and pelvic drags as well as pressure, especially in pregnancy; it has intensified the sexual functions in man, the results of which are frequently untoward and even dangerous; it has caused an enlargement in the size of the head in the human foetus, which necessitated a consequent enlargement of the pelvic cavity, and there are doubtless still disharmonies between the two conditions; it has resulted in greater relative slenderness of bones and even skull, rendering them proportionately more liable to injuries; it has brought about greater delicacy of skin, with consequent less resistance of the body to exposure; it has induced especially a great enlargement of the brain, a process the results of which to this day offer many imperfections; and, finally, while evolution has doubtless improved various immunities in man, it

is still very incomplete in this respect, and, on the other hand, it has evidently led to new dangers and predispositions. There seems to exist even some indications that it may in some of the most advanced groups adversely affect the ability of procreation.

The evolution of man will continue, and in order that it shall proceed with the least harm and towards the greatest benefit of mankind, it will require the most enlightened and increasingly important help and service of all branches of medicine.

Dr. W. P. Carr had enjoyed Dr. Hrdlicka's address very much; had never heard the theory of evolution so fully and systematically presented before, nor had any other presentation of the subject, so far as he knew, been accompanied by so ample and satisfactory evidence. A good many years ago he had many arguments on this subject, and could never persuade himself to accept the evolutionary idea as it was then presented; there seemed to be too great a gap between the highest forms of the lower animals and the lowest forms of man, and the possession of intellect, of reason, and the idea of the soul in man seemed to mark an insuperable barrier between mankind and the lower biological orders. But with the unmistakable evidence of the very extreme antiquity of man, with the evidence of the evolution of lower animals and the evidence of the same sort of adaptations and changes in man, it is unavoidable that one believe that man is subject to the same biological laws that obtain in other natural orders. When we come to consider the influence of evolution on human pathology, he could observe many things that make it clear that much of our pathology must depend upon unperfected evolutionary adaptations; perhaps cancer may be mentioned as one of the diseases which probably has an ultimate basis of this sort. And it seemed to him that the rapidly increasing civilization in which man dwells, the tendency to become more and more urban and to depart more and more from simple conditions of life, must have a profound effect upon his future evolution.

Dr. Hrdlicka wished to accentuate the fact that evolutionary changes are not all constructive or that all tend towards the greater perfection of the type, for, in fact, many of these changes are degenerative and tend towards the elimination of structures which have become less necessary under the changing conditions, the retention of which would nevertheless be of advantage. The fulcrum of evolution is physical adaptation to changing conditions, or, speaking comprehensively, to environment. If the environment is such that it arouses what we might call the best efforts of the organism and keeps on doing so, development can safely be expected in that direction and in the main towards improvement in the type. If, on the other hand, the environment is adverse, the type must eventually lose, unless it develops within itself effective defensive means, such as immunities, etc., against

the degrading influences. Civilization affects man's evolution only as a portion of his environment and in accordance with the general rules just laid down, and may harm as well as improve.

There is, as already said, evidence that human evolution is by no means completed, but that it is progressing, and among the higher civilized white men it is possibly progressing even more rapidly than in former times. This is due to the diversities of new stimuli and the potent stresses to which modern civilization subjects us.

Dr. S. S. Adams was sure that he voiced the sentiment of the whole Society when he expressed our great appreciation of Dr. Hrdlicka's address. He moved that Dr. Hrdlicka be given a rising vote of thanks.

GENERAL CONSIDERATIONS WHY MEMBERS OF THE MEDICAL PROFESSION SHOULD RECEIVE HIGHER COMPENSATION THAN OTHER PROFESSIONS AND SCIENTIFIC WORKERS.

By George H. Heitmuller, A. B., M. D.,

Washington, D. C.

The preliminary educational qualifications are greater than for any other utilitarian profession.

The course of study is longer than that of any other profession.

The course is not free, as in the military, naval and theological professions. There are comparatively few medical scholarships as compared with the number of students and as compared with other scientific branches.

The cost of a medical education is therefore greater for almost all students than for any other profession.

The practice of medicine entails more anxiety, care and hard work than any other. The hours are irregular, sometimes all night, etc.

The active careers of most physicians are shorter than for other professions. Other reasons will suggest themselves to the committee.*

PROBABLE CAUSES OF INADEQUATE REMUNERATION OF THE MEDICAL PROFESSION.

By reason of its altruistic work in and outside of clinics, hospitals and dispensaries, the profession has given the laity, or at

* Reported to the Executive Committee of the Society, and by the Society directed to be published in the Annals.

least the laity has become saturated with the idea that the services of physicians are not worth anything, or that they do not need money.

This is further encouraged by allowing various institutions, both public and private, such as insurance companies, manufacturing plants, commercial and other companies, orphan asylums and other semi-public charities, to contract for medical services for a great deal less than they are worth ; these latter institutions feel that they have amply recompensed the physicians when they pay $25.00 a year, and permit him to gain so-called experience.

The profession assists in the cheapening of its services by permitting the various steps toward the socialization of medicine, such as physicians to the poor, police and fire surgeons, medical inspectors of schools, etc., without insisting upon proper remuneration for those thus employed.

It may be altruistic to the general public to give free services in the clinics, yet it is anything but altruistic to those members of the profession who are not able financially to give free services, and who might be employed in this work if it were properly paid. The community can hardly expect the profession to continue indefinitely to give free services when the increasing cost of education and living is considered. It is no argument in favor of the old method that there is a gain to the physician in experience in the clinic ; so is there a gain in experience to the lawyer employed in public service, but he insists upon being paid just the same ; and then the gain in experience in the clinic is usually very small after the first six months.

When the medical employees of the District Government receive adequate compensation, the disappearance of the 25, 50 cent and one dollar fees may be expected, not before.

Before passing on to the individual positions it seems to me that a minimum salary for medical employees should be determined upon by the committee ; in determining this minimum, in addition to the considerations given above for higher remuneration for the medical profession, there should be taken into account the demands upon the physician's purse for a higher standard of living, for society dues, for journals, for attending conventions, etc. Personally I think the minimum pay for whole time services, no private practice allowed, should not be less than $1,800.00.

I hope the committee will agree with me on this amount or a higher amount as a basis for further consideration of the subject.

The following is a list of the various medical employees of the District of Columbia with their salaries. It will be noticed that the law does not require some of the places to be filled by physicians ; however a knowledge of medicine is required to properly fill them.

Health Department.

No. 1.	Health Officer,	$4,000.00
2.	Assistant Health Officer,	2,500.00
3.	Chief Medical Inspector (contagious diseases), per diem,	6.00
4.	Medical Inspectors, contagious disease service, each, per diem,	$4.50 and 4.00
5.	Medical Inspectors of schools, each, per annum,	500.00
5a.	Bacteriologist, per diem,	6.00

Police and Fire Departments.

6.	Police and Fire Surgeons, each,	$720.00

Board of Charities.

7.	Physician at Workhouse,	$1,350.00
8.	Attending Physician at Jail,	1,200.00
9.	Resident Physician at Jail and Washington Asylum,	480.00
10.	2 Assistant Resident Physicians, Washington Asylum, each,	120.00
11.	Supt. Tuberculosis Hospital (not required to be a physician),	1,800.00
12.	Resident Physician, same Hospital,	600.00
13.	Pathologist, same Hospital,	300.00
14.	Physician for Home for the Aged,	480.00
15.	Pathologist, Washington Asylum,	600.00
16.	Anaesthetist, Washington Asylum,	300.00
17.	Operator of X-Ray machine, Washington Asylum,	600.00
18.	Physicians to the poor (22), each, per diem,	1.00
19.	Chief Clerk, Application room, Board of Charities,	1,200.00
20.	Inspector, Board of Charities,	1,000.00

These two officials (19 and 20) are not required to be physicians:

21.	Coroner,	1,800.00
22.	Alienist,	1,000.00

CONSIDERATION OF THE PARTICULAR CLASSES OF MEDICAL EMPLOYEES.

No. 1, *Health Officer*, salary $4,000.00; comparable positions are Judges of the Supreme Court of the District of Columbia and Superintendent of Public Schools, with salaries of $6,000.00 for each class. The Health Officer has thirty days annual leave; the other classes at least three months. The present occupant of the office has been physician to the poor, and coroner of the

District. He is a graduate of law and medicine and is instructor in both branches in the local schools. His standing in the country is the highest; he is Ex-president of the American Public Health Association (composed of the health officers of North and South America); also Vice President of the American Medical Association. He has recently been offered the position of President of the Board of Health of New York City. The Health Officer at his own expense attends numerous meetings in other cities in order to keep abreast of modern sanitary methods. The Superintendent of Schools attends meetings to a less extent, and Judges not at all, for the purpose of keeping informed.

It is not contended that the other classes are overpaid or even adequately paid, but that the Health Officer should at least have the same compensation, his responsibilities and duties being greater and more exacting.

The Commissioners of the District of Columbia are not comparable to the Health Officer, because these officers are palpably underpaid, and are not professional men.

No. 2, *Assistant Health Officer*, salary $2,500.00. Comparable positions, Clerk of the Supreme Court, salary $5,000.00; Corporation Counsel, salary $5,500.00; Assistant Superintendents of Public Schools, salaries $3,000.00. Both of these classes are able to do outside work to supplement income, while the Assistant Health Officer can not do so, owing to long hours of duty, sometimes being employed up to 9 o'clock at night and very frequently on Sundays. In the matter of leave the Assistant Superintendents of schools have three months; Assistant Health Officer has only thirty days. The Assistant Health Officer's salary should be at least $3,600.00.

No. 3, *Chief Medical Inspector*, salary $6.00 *per diem*. Comparable positions same as above. This officer is exposed constantly to virulent and incurable diseases; he treats all smallpox cases and leprosy cases that occur in the District, and as there is no pension for this or any other medical position, and as the contracting of the latter named incurable disease entails permanent segregation, the injustice and inadequacy of a $6.00 per diem compensation is manifest. The compensation should be at least $12.00 with a pension in case of incapacity due to contracting a contagious disease.

No. 4, *Medical Inspectors*, salaries $4.50 and $4.00 each *per diem*. Comparable positions, Supervising Principals of Public Schools, with minimum salaries of $2,200.00, rising by $100.00 annually to $2,700.00, and three months annual leave. In the case of an inspector employed entirely inside of office, there is no opportunity for private practice, and he has one month leave. Inspectors in the field receive no pay when not employed. Salaries should be at least $6.00 to $7.00 *per diem*. Medical Inspectors must furnish their own transportation.

No. 5, *Medical Inspectors of Public Schools*, salary each $500.00. There are no positions under the District government comparable to the above. Medical inspectors are required to work three hours a day, but this is divided into two parts, one and a half hours between 9:30 and 12 A. M., and one and a half hours between 1:30 and closing of school, thus entailing a double visit to the schools from the inspector's office ; the time lost in thus going backwards and forwards is not counted in the three hours required. No transportation is supplied ; in the case of an inspector who has no automobile and who must use street cars it practically takes the entire day from 9 to 3:30 P. M. to perform his three hours duty and then return to his office to attend to such private work as he may have. Transportation on street cars, amounting to about $5.00 per month, must be deducted from the salary ; likewise thermometers must be furnished by inspectors out of the salary. Medical inspectors not only inspect to prevent communicable diseases, but also examine for physical defects and also to determine the mental condition of pupils with the view of segregation in special classes ; also make a full physical examination of all candidates for the normal schools. Medical inspectors in New York and other places working 3½ hours receive $1,200.00. While this does not appear to be sufficient, every effort should be made to have the salaries of the local inspectors raised to at least $1,200.00.

No. 5a, *Bacteriologist*, salary $6.00 *per diem*. Comparable positions, Assistant Superintendents of Schools, at $3,000.00. The present incumbent of No. 5a is without a peer among the bacteriologists of the country. He not only makes bacteriological examinations for the diagnosis of disease but also makes bacteriological examinations of food articles, etc. He is likewise pathologist at the Tuberculosis Hospital, for which he receives $300.00 per annum in addition to the $6.00 *per diem*, but this is entirely inadequate for the amount and quality of the work performed. In view of the expected extension of the work of the bacteriological laboratory to include the biologic test for venereal diseases, the salary for this office should be at least $3,600.00, and he should not be expected to be pathologist for the Tuberculosis Hospital in addition.

No. 6, *Police and Fire Surgeons*, salary $720.00. There is really no comparable position to the above, but the fact that the veterinary surgeon receives $1,200.00 per annum would seem to indicate that either the lives of the horses are of more account to the District than of the police and firemen, or the services of the veterinarian more valuable than those of the medical man. The salaries of the above officials should be at least $1,800.00 per annum.

No. 7, *Physican at the Workhouse*, salary $1,350.00. Comparable position, Superintendent of Workhouse, salary $2,500.00. The

physician at the workhouse should receive at least as much as the superintendent.*

No. 8, *Attending Physician at Jail*, salary $1,200.00. Comparable position as No. 7. Corresponding officers in other municipal hospitals receive from $3,500.00 to $5,000.00 per annum; the salary should be at least $3,500.00.

No. 9, *Resident Physician* at Washington Asylum, salary $480.00.*

No. 10, *Assistant Resident Physicians* $120.00. There are no comparable positions except as to hours and conditions of service, and these positions are the guards at the jail, with salaries of $600.00 to captain with $1,200.00. Of course the qualifications of these positions cannot be compared with those of resident physicians, and thus the inadequacy and absurdity of the salaries of the resident physicians are apparent. As a matter of fact the District has adopted the expedient of promising to the resident physicans at the various Government institutions, promotion to other medical positions, in order to keep residents, and even under these conditions residents do not stay. The salaries of resident physicians should be $1,200.00 for assistant residents, to $1,800.00 for resident physicians.*

No. 11, *Superintendent of Tuberculosis Hospital.* Not required to be a physician, but as he is a physician the salary should be at least equal to the minimum of medical superintendents, namely $3,000.00 instead of the present salary of $1,800.00.

No. 12, *Resident Physician at Tuberculosis Hospital.* The comments Nos. 8 and 9 apply here. The salary should be $1,800.00 instead of $600.00.*

Nos. 13 and 15, *Pathologists* at Washington Asylum and Tuberculosis Hospitals, and Nos. 16 and 17, *Anaesthetist* and x-ray machine operator at Washington Asylum Hospital, are evidently part-time employees. There should be a readjustment of the duties of these positions so that they may be made full time with salaries of not less than $2,000.00. For example: One pathologist for Washington Asylum and Tuberculosis Hospitals, with salary of not less than $2,000.00, and anaesthetist and x-ray operator with salary of $2,000.00.

No. 14, *Physician for Home for the Aged*, salary $480.00; should be raised to $1,200.00

No. 18, *Physicians to the Poor;* salary $1.00 *per diem.* There are no positions that in any way approximate these salaries; the nearest to them is that of street sweepers at $1.50 per day, and drivers of garbage and street cleaning wagons at $1.75 per day. Arguments may be brought to the effect that physicians make few visits a day on the average, and so on. It must be remembered that few visits will be made at the period of the year when

*Of course Resident Physicians and Assistant Resident Physicians have quarters and board, and sometimes laundry, gratis. [Editor.]

all physicians are slack, and that numerous visits will be made at the time when everybody is busy ; that is : when the physicians to the poor have the opportunity to do more private work by reason of the greater prevalence of illness, the greater demands on them by calls from the poor, owing to the same greater prevalence prevent their increase of private work. It must be remembered also that they must be always available or they receive no pay ; likewise they must make two calls a day at the police precinct in their district. They are forced to treat cases abandoned and often *in extremis*, by private physicians. The compensation should be at least $4.00 *per diem* with thirty days annual leave.

No. 19, *Chief Clerk, Application room Board of Charities*, $1,200.00. Comparable positions : First Assistant Corporation Counsel, salary $2,500.00. This official is able to do private work which the physician filling position 19 is unable to do. Supervising Principals of Public Schools with a minimum salary $2,200.00, increasing by $100.00 annually to $2,700.00. Clerk to Police Court $2,200.00. The chief clerk is required to be a man of executive ability, *a Physician*, and act as chief clerk or inspector of the application bureau. He has supervision of admission of indigent persons to the various hospitals, Home of the Aged and Infirm, District children sent to the Maryland School for the Blind, cases sent to the Florence Crittenton Mission, transportation of stranded persons and non-residents who become charges upon the District in the various public institutions ; supervision of the investigation of District patients admitted to the Government Hospital for the Insane, as to indigency, etc., and the deportation of the non-resident cases ; interviewing, making records and issuing permits for the treatment of patients in the various hospitals and dispensaries ; detailing physicians to the poor to visit indigent patients. He is held responsible that no person suffering with a contagious disease who personally applies at the application bureau shall be allowed in a general hospital ward or mingle with the people. He has supervision of the certifications of other physicians for applicants for hospital treatment, personal charge of the ambulance service, and dispensing of diphtheria antitoxin to physicians to be used for indigent persons ; interviewing applicants for surgical appliances such as artificial limbs, trusses, elastic bandages and numerous other details requiring expert medical knowledge.

The Board of Charities, for the fiscal years 1913, 1914, 1915 and 1916, recommended to Congress that the clerk be designated chief clerk, and the salary increased from $1,200.00 to $1,500.00 per annum, but each year the item failed to pass. This increase recommended by the Board of Charities is wholly inadequate ; it should be $2,400.00.

The following is taken from the annual report of the Board of Charities for the year 1913, in the estimates for the fiscal year to

end June 30, 1915. Note: This man is in charge of the application bureau of the Board of Charities, and handles about 18,000 applications a year. He *must* be a physician as well as a man of executive ability.

Dr. George M. Kober, Vice President of the Board of Charities, in 1914 made the following recommendation to the Committee on Appropriations in Congress. "We ask for a slight increase in the salary of the clerk, who is practically the chief clerk of our application bureau. He deals with about 17,000 to 18,000 applications a year. *He must be a physician* because most of the applications are applicants for admission to hospitals or almshouses or orphan asylums, and some professional knowledge is necessary to enable him to do the work intelligently and faithfully. We make a strong appeal to have this salary increased. He handles about 17,000 to 18,000 applicants during the year, he is the chief executive of the application office, and as such sifts charity from abuse." From the foregoing it is evident that the salary of $1,200.00 is wholly inadequate for the service rendered, and that the position should have a more appropriate designation than that of clerk. To show the medical character of the position, perhaps a better designation would be Physician in charge of Application Bureau of the Board of Charities. Salary $2,400.00.

No. 20, *Inspector*, Application Room, Board of Charities, salary $1,000.00. This official is not required by law to be a physician, but a knowledge of medicine is necessary to fill the position as in No. 19. The salary should be at least $1,800.00.

No. 21, *Coroner*; salary $1,800.00. Every physician is familiar with the character of the work, the responsibilities of the position and also perhaps with the time required. It may be mentioned that last year between 1,600 and 1,700 investigations were made by the Coroner, and this together with inquests takes up all of his time so that practically no opportunity for private practice is available. The salary should be at least $3,600.00.

No 22, *Alienist* (under courts), salary $1,000.00. Here, again, every physician is familiar with the character of the service rendered, the expert knowledge required, the amount of time necessary to fully study the cases, and the actual time consumed in court in giving testimony. The salary of this position should be be at least $3,000.00.

No doubt objections of every kind will be raised to defeat the just increase of salaries for medical officers advocated in these notes, and economy and inability of the District to pay will be urged, but it should be borne in mind that just at this time, when there is an investigation of the question whether or not the District of Columbia is able to meet nearly if not entirely its own expenses, is the time to refute the claims of certain members of Congress that the District is not able to expend efficiently twice the amount raised in taxation. Now is the time to make a con-

certed effort to get adequate compensation, sufficient numbers of employees of the various medical services of the District, and finally, a more adequate compensation of physicians rendering services to the community in the capacity of witnesses before the courts. The $1.25 paid physicians testifying in civil and other cases as experts, not as ordinary laymen, after waiting around all day until called, is simply preposterous. Fifteen dollars should be the fee.

TWO CASES OF SPASTIC PARALYSIS.*

By R. F. Dunmire, M. D.,

Washington, D. C.

P. and T. D., brothers, white, age 6 and 7½ years respectively, born in the District. Both had normal birth and were breast fed. The younger child had pneumonia when 2 years old; the older child had intermittent fever at 3 years. Family history negative except that in the father's family there was tuberculosis.

The onset of present illness in the older child was in September, 1914, when he complained of being weak and tired on moving his legs. He was clumsy in his walk, or, as his mother described the condition, "weak in the knees," eventually being unable to run at play with other children. There were frequent complaints of pain in the kneejoint, but of little severity. The condition progressed until a characteristic mode of walking resulted, the body being elevated slightly on the toes of one foot, the weight being thrown forward to the ball of the extended foot, dragging the toes; legs separated to a marked degree on standing, the weight of the body was entirely supported on the toes and balls of feet. School life was limited to three months on account of his inability to walk; during this period he was considered extremely backward in his studies.

In the latter part of December, 1914, and during January, 1915, both children were confined to bed with scarlet fever, at which time no special observation was made of above condition in the older child.

The younger child, about April 1, 1915, became cross, irritable and quite dull. When he walked he moved like the older brother with a tendency to sway to the left side. This child was also noticed to be considerably more rigid in the calf muscles than the older one. While sitting there was a tendency to complete extension of the feet. Within several weeks the entire lower limbs presented spastic rigidity.

I first saw these cases July 1st. At this time both children were able to sit and stand alone, but could walk only with ex-

* Presented to the Medical Society, October 20, 1915.

treme difficulty. The gait was of the pouncing-toe character; the legs rigid, feet and toes extended; lumbar muscles rigid.

The older child was well nourished, and quite bright in general appearance. The younger was small, anemic and idiotic. In both there were choreic movements of both limbs and head, to a much greater extent in the younger child, so that it was impossible for him to make any voluntary movements with his hand, which at the same time had a claw-like grasp. His head was constantly shaking from side to side. The extensor and adductor muscles of the lower extremities were rigid. Fine tremor and typical scanning speech in both cases. The deep reflexes extremely exaggerated, with no sensory disturbances. Sphincter muscles unaffected. Babinski sign and ankle clonus positive. Pulse in older child, 120; in younger, 130. Urine analysis showed slight trace of albumin. Wassermann test showed blood negative, and spinal fluid negative. Blood in older child showed 15,000 leucocytes; in younger child, 18,000.

The condition of the older child to the present time has changed but little, except that he is unable to walk or support the body without assistance, has gained some weight, the choreic movements having disappeared entirely, the tremor and spasticity still remaining.

The condition in the younger child has progressed much more rapidly. He is unable to walk or sit, the muscles of both legs and back being spastic, producing complete rigidity of the entire body. The arms are slightly involved, voluntary movements being quite impossible. Choreic movements, except those of head, have disappeared.

No wasting exists in either case.

Dr. W. P. Carr said that what interested him most about these cases was the ultimate cause of the condition. Dr. Williams spoke of insular sclerosis as the cause, but this was no more definite so far as the ultimate cause was concerned than was the term lateral sclerosis. In the case of these boys, there was evidently both cerebral and cord sclerosis and the cause of the condition had been the same in both places. Dr. Carr doubted if the disease was due to a congenital degenerative influence; it was hardly likely that any one set of elements in the body would be so constituted that they would live less long than others. Such an idea would itself require an elaborate explanation. He had always thought that scleroses of this sort were due to some poison coming in contact with nerve cells, with selective action. Syphilis produced its effects in this way. Other acute infectious diseases might affect the nervous system in the same way. Neuroglia might also be affected by metabolic poisons. There must be some inflammatory reaction going on in these boys at this time; this idea is supported by the leucocytosis present.

Dr. Randolph understood that these boys recently had scarlet fever. What was the time relation of the scarlet fever to the onset of the paralysis?

Dr. Dunmire said that scarlet fever followed the appearance of paralysis in the older boy but antedated it in the younger.

Dr. Barton said there could be no doubt that in the case of these boys there was some disorder of the lateral tracts. There was no evidence of sclerosis, however; no more than in other cases. The original disease was in the cortex. The anatomical diagnosis was of a lateral disease; there was no evidence of sensory degeneration and no muscular atrophy. Why might not this be a poliomyelitis, in these cases affecting the cortex instead of the lower neurone cells? Such an assumption was not impossible and, moreover, would afford a far more hopeful prognosis than could be extracted from the diagnosis of a system degeneration.

Dr. Tom A. Williams said that acute poliomyelitis could not account for the condition of these boys. In the first place, the disease affecting them was progressive; poliomyelitis after the first flash is regressive; thus the course does not correspond; nor were the boys affected together; the older boy had been sick for months before the symptoms appeared in the younger. Dr. Barton was quite right in saying that lateral sclerosis is not a spinal disease; it is a system degeneration due to cortical disease. It was Gowers, Dr. Williams believed, who wrote a whole book on abiotrophy, a subject which Dr. Carr dismissed so cavalierly; by abiotrophy we mean the premature death of a system. There are such conditions, and probably due to endogenous causes. There is a lateral sclerosis, however, which is due to an exogenous poison, namely: lathyriasis, a disease due to a poison from the vetch. Of course, insular sclerosis was not an ultimate diagnosis; but the term enabled one to put patients suffering from the condition into a definite class. In the present cases, the disease was due to some acute infectious process; for it was accompanied by a leucocytosis and there was a lymphocytosis of the spinal fluid; this latter symptom may finally have disappeared. Sclerosis of the nervous system does not differ from sclerotic changes elsewhere in the body; it is exactly the same organization of inflammatory elements. There may be a replacing or a hyperplastic process, depending on the underlying conditions.

Color Blind?—Little boy from the Canadian Northwest, visiting bachelor uncle in Chicago, saw for the first time in his life a colored woman, and asked his uncle why the lady blacked her face. "That's her natural color; she is a negro," said Unc. "An' is she as black as that all over?" asked the boy. "Sure she is," said Unc. "Tee!" said the kid, "you know everything, don't you uncle."

RECTAL EXAMINATIONS DURING LABOR.*

By Prentiss Willson, M. D.,

Washington, D. C.

Every woman who becomes pregnant is subjected to the danger of infection, because the termination of pregnancy, be it by abortion, miscarriage, premature labor, or labor at term carries with it this ever-present risk, to minimize which is the first duty of the obstetrician. That the efforts of the profession have not been crowned with any too great measure of success in this direction is rather forcibly called to mind by Williams' recent paper on the status of obstetrical teaching in the United States and by Moran's recent Presidential address before the local Obstetrical and Gynecological Society. It were well, possibly, not to dwell too strongly on this point, so let us be content with observing that the results of Williams' questionnaire regarding the relative incidence of puerperal infections in the practice of physicians and midwives seem to prove the soundness of the old adage that comparisons are odious, but in a manner possibly not to the taste of this audience; while Moran shows that the census figures from the registration area for the years 1900 to 1913 give an average of 45 per cent. of the total death rate from childbirth as due to sepsis, with a minimum of 39+ per cent. in 1906 and a maximum of 47+ per cent. in 1911. Such considerations as these cannot but give weight to any suggestions, no matter how trivial, looking, possibly, toward the reduction of *post-partum* sepsis.

If one but look at the etiology of puerperal infection from the broadest possible viewpoint, the conclusion is inevitable that the source of infection is exogenous in the great majority of cases. Theoretically, of course, a blood-borne infection of the recently-delivered uterus is eminently possible but even more eminently improbable. I do believe that in rare cases acute and virulent puerperal infection is the result of the lighting up, so to speak, of an old chronic infectious focus in the genital tract. But these cases only serve as the exceptions which prove the rule—that puerperal infection is the result of the introduction of pathogenic organisms into the genital tract either before, during, or after labor. And for this introduction the accoucheur must stand ready to take the blame.

The history of the development of modern obstetrics will show, I believe, that its trend is toward a wisely and discretely limited policy of *laissez faire*. One has but to consider the abandonment of the pernicious and dangerous *ante-partum* antiseptic douche, the universal acceptance of Crèdè's method of dealing

*Read before the Medical Society, January 13, 1915.

with retention of the placenta and the popularization of abdominal palpation as a means of obstetrical diagnosis to be convinced of the truth of this statement. It must not be said, however, that modern obstetric teaching is tending toward the position that civilized woman and her unborn child should be managed during labor without a constant and exact idea of the stage of the delivery and the character, physiological and pathological, of the mechanism. Such a course would swiftly and surely lead to disaster. On the contrary, modern obstetrics demands from the accoucheur, in ever-increasing degree, a constant watchfulness during labor, not only in regard to the points mentioned, but in regard to every possible indication of the welfare of mother and child. It does further insist for this, however, that the information necessary for the proper, careful and complete watchfulness of the course of labor shall be obtained in such manner as to least expose the mother to the risk of infection.

It is for this reason, then, that I wish to call the attention of the Society tonight to a method of obstetrical diagnosis which I believe to be safe, practical and efficient, and yet, at the same time, locally as well as generally, more honored in the breach than in the observance. I refer to the use of rectal examinations during labor to supplant and largely do away with the necessity for the more commonly used vaginal examination. In the diagnosis of presentation, position and variety during pregnancy or labor, and in following the course of the mechanism of labor itself, the accoucheur has available the following methods of examination: radiography, abdominal auscultation, and abdominal, perineal, vaginal and rectal palpation. It may be said of all these methods, with one exception only, namely, vaginal touch or palpation, that with any degree of care they are free from danger to both mother and child. It may be claimed that vaginal examinations, made with care, are free from danger, but unless considerably qualified I doubt if the correctness of this assertion can be maintained. With proper technique, *i. e.*, the use of a properly-sterilized glove drawn over a properly-sterilized hand, in the proper manner, so as to avoid touching the outside of the glove with an ungloved hand, the examining hand as a source of danger is practically eliminated. But it is obvious, even with the most skillful technique, that it is practically impossible to avoid carrying up from the introitus any infectious organisms which may chance to be present. While the chance of such implantation resulting in puerperal infection may be slight, at the same time it cannot be dismissed too quickly with this statement. A proper estimation of the danger involved could only be obtained by a study of the mortality and morbidity from puerperal infection in two very large series of cases, in one of which labor had been conducted with vaginal examination and in the other without. I think there can be

little doubt as to which series would show the better results. And then to truly evaluate the importance of the question, the difference in the percentage of puerperal morbidity should be figured against the total number of births for the country as a whole. The conclusion seems inevitable that a method of conducting labor which does away entirely with vaginal examinations in normal cases, greatly reduces their number in abnormal, provided only that the information usually gained in this manner be obtained, and in a less dangerous way, marks a distinct advance in obstetric technique. In my limited experience I have demonstrated to my own satisfaction that rectal, abdominal and perineal palpation may safely be permitted to very greatly reduce the frequency of vaginal examination, in normal cases to its practical exclusion.

Vaginal examination during labor is, or should be, used for obtaining the following items of information: 1. The condition of the cervix. 2. The condition of the membranes. 3. The presentation, position and variety. 4. The station of the presenting part. 5. The presence of abnormalities of child or mother. 6. The internal pelvic measurements. 7. The character and amount of the vaginal secretions.

The efficiency of rectal examination may be best judged by considering how much of the above information may be obtained by its means. The condition of the cervix is readily made out. The recto-vaginal septum is invaginated through the external os, and the degree of dilatation of the external and internal os, the degree of effacement or taking up of the cervix and the consistency of the part are all readily ascertained.

When the use of rectal examinations during labor was first called to my attention, the first point I made against it was the apparent impossibility of determining the condition of the membranes. This impossibility, usually, does not exist. With a protruding bag of waters, palpation *per rectum* during a pain enables an immediate and positive diagnosis of unruptured membranes. Even when the cervix is just beginning to dilate, the palpating finger in the cervix covered by the recto-vaginal septum, can detect a fluctuating part in front of the head during a pain. Of course when there are no fore-waters, and the membranes are tightly applied over the presenting part, diagnosis of their condition would be as impossible by rectum as it is difficult by vagina.

The palpation of the presenting part is quite satisfactory *per rectum.* The differentiation between vertex and breech is as readily made as by vaginal examination. The consistency of the head, the direction of the fontanelles and sutures, and hence the position and variety of the presentation, can be quite readily ascertained with a little practice, particularly when the cervix is dilated sufficiently to permit invagination of the septum through

it. Of course when the head has to be palpated through the undilated lower uterine segment, certainty is more difficult to obtain, but is by no means impossible.

Vaginal examination is not uniformly definite or satisfactory under these circumstances. When the head has escaped from the cervix and questions of the degree of its descent and rotation are to be answered, rectal examination will give the desired information in a few seconds. In the detection of abnormalities of presentation, aside from cases of breech and posterior varieties of vertex presentation, I have not had the opportunity to make use of rectal examination. I believe, however, that such abnormalities, including transverse, compound and face presentations, and prolapse of the funis, could be readily detected, as could tumors of the maternal structures, strictures of the vagina and other obstructive difficulties of maternal origin. At least there would be sufficient evidence of radical departure from the normal to indicate a more thorough examination *per vaginam*. Internal pelvic mensuration is, of course, impossible by rectum, although a very good idea of the conformation of the posterior pelvic wall may be obtained. When indicated by abnormal external pelvic dimensions, however, thorough internal pelvic mensuration should be done during late pregnancy, or at least a month prior to the time of labor, at which time vaginal examination is without danger. The character of the vaginal secretions cannot, of course, be determined in this way, although this is a minor point for the determination of which inspection is often alone necessary.

It is thus seen that most of the information to be derived from vaginal examination can be obtained by examination *per rectum* at what must be acknowledged must be a lessened risk of infection. There remains to be considered, then, the technique of the procedure, its general advantages, and the real or imaginary objections which have been urged against it.

The technique is, of course, exceedingly simple. Gloves should, of course, be worn, from considerations of ordinary cleanliness and to avoid contamination of the hand with colon bacilli. For this reason, also, it is important that the glove be perfect and free from minute perforations. Special gloves, made up of a cuff to go over the closed hand and one finger only, may be had, and present the advantage that they would naturally be kept for this one purpose. The gloved finger is anointed with lubricant and introduced directly into the rectum. Washing the patient, or examining hand, sterilizing the glove or lubricant are all entirely unnecessary. It is probably best to use the middle finger for the examination because it is longer and because with the hand held in extreme supination the other fingers and thumb lie under the patient's buttocks and do not at any time come in contact with the region of the vulva. There is some difficulty at

first, however, in training the tactile sense of this finger to equal that of the more frequently used index finger. When the examination is over the glove is withdrawn and washed or washed and boiled, depending upon whether or not it is kept for rectal examination alone, which is the better way.

As a result of my experience with this method of examination I feel justified in claiming for it the following advantages over the more used vaginal method: First, and most important, there is less risk of infection and because of this fact there follow many other advantages as a direct consequence. Thus rectal examinations may be used *ad libitum* during the course of labor and an increased and valuable knowledge of the mechanism is the certain result. Students may be allowed to make these examinations with impunity, whereas in the case of vaginal examinations I can never rid myself of the feeling that in permitting even one or two of them by a student I am not subserving the best interests of the patient. In the work of an obstetrical clinic the importance of this last point is hard to overemphasize. To the busy practitioner the freedom from the troublesome and, above all, time-consuming, aseptic technique gained by the routine adoption of this method is most welcome. The examination is made, we will say, an undilated and untaken-up cervix diagnosed, permitting absence from the patient for some time, in less time than it ordinarily takes to get together the necessary implements for "scrubbing up." Another important advantage is a greatly lessened likelihood of premature rupture of the membranes during the first stage of labor. In the majority of instances, also, rectal examination is less painful to the patient than vaginal, and I can see no reason why it should offend her sensibilities more, or for that matter, less.

In conversation with my friends regarding the results of this method of examination, certain objections have been made which should be given consideration. There is a very healthy skepticism, in the first place, in regard to the amount and reliability of information to be derived in this way. I can only urge that it be given a fair trial and state that I approached its use in the same spirit and with the result of a speedy conversion. The most serious objection raised is the statement that its frequent use would be bound to contaminate the hands or gloves with fecal matter which later might be introduced into the genital tract, thus producing a *post partum* infection as the result of leaning over backward, as it were, in the effort to avoid it. If the technique recommended before be followed, I am convinced this fear must needs be proved to be chimerical to a degree. In order that there should be danger of this character it would be necessary for the following breach in technique to occur: First, the glove used in the rectal examination must be defective, and this point is easily deter-

mined before it is put on. Second, the technique of preparing the hands for subsequent vaginal work or delivery must be defective. Third, the gloves worn at the time of delivery must be also defective, or must be drawn on with an imperfect technique, or must be torn in the course of delivery or subsequent operation. If the same hair-splitting objections be allowed to obtain against any accepted surgical procedure, it must of necessity stand condemned.

In conclusion I can only say that the use of rectal examinations during labor, to avoid as much as possible vaginal exploration, receives the hearty and enthusiastic support of two of the best known treatises on obstetrics by American authors.

Dr. Moran usually found himself in full accord with views expressed by Dr. Willson, but on this occasion he had some reasons to dissent. He had not himself had experience with the method described in the paper; but to him it seemed that it is a method not necessary to be employed by the trained physician, and one which in the hands of the untrained accoucheur might constitute an added danger to the patient. What is really needed is that the schools shall teach more thoroughly proper obstetric technique to the students.

Dr. Bowen said that when the title was announced he had had no idea that such an interesting paper could be made out of the subject. The paper had made the claims for the method very strongly and well; but the field of usefulness of the method, it seemed to him, was quite limited. He had used the method on a number of occasions and could agree with Dr. Willson that the condition of the cervix can be made out very well.

Dr. Brown Miller felt very grateful to Dr. Willson for the paper. He had used the method of rectal pelvic examination a great deal for general work, especially in gynecologic cases. He had not used it in cases of labor, however, and could not believe that we can get the same information as by vaginal examination.

Dr. I. S. Stone felt sure that Dr. Willson had presented the subject only after mature study and much experience. Dr. Stone regretted that those who had discussed the paper had not unfolded all the reasons lying under their objections to the method advocated therein. He hoped that Dr. Willson would not be deterred from using the method by the criticisms offered.

Dr. T. C. Martin said that in his character of proctologist he might be regarded as having no desire to reduce occasion for traumatic diseases of the rectum. In the spirit of preventive medicine, however, he wished to discuss the paper to the extent of remarking that in order to avoid injuries to the anal region the finger should not be introduced into the rectum. On the other hand, the examining finger, well lubricated, should be

placed against the anal orifice and the patient instructed to make an expulsive effort; in this manner the rectum can be made to climb upon the examining finger and all harm be avoided.

Dr. Lochboehler asked what Dr. Willson did in cases of pathological conditions of the anus; *e. g.*, hemorrhoids, fissure, etc.?

Dr. Paul Johnson said that in spite of the adverse comments he believed that Dr. Willson had done a valuable service to bring this subject to the attention of the Society. Dr. Johnson had used the method frequently, not as expertly as Dr. Willson, but with satisfaction in obtaining much valuable information in cases of labor. He could see no reason why for purposes of securing ordinary obstetric information the method should not be used. Surely it should be a source of great comfort to the obstetrician to be able to put on forceps through a vagina previously uninvaded.

Dr. Kober said that it seemed to him that any method devised to diminish the danger of puerperal sepsis should by all means be given a thorough trial; but it should be suggested that the method might encourage carelessness in the disinfection of the hands and so give rise to danger when some sudden emergency required the introduction of the hand into the uterus. He expressed the hope that the method might be given a thorough trial and that statistics might be compiled to compare the method with ordinary vaginal examination.

Dr. W. P. Carr said that it seemed to him that the question should be taken up not so much for the benefit of careful men but for careless men. With proper technique the danger of vaginal examination is practically nothing. Dr. Willson said in the paper that 45 per cent. of deaths after labor are due to sepsis; but very few deaths, as a matter of fact, occur in view of the total number of deliveries. And it would be very hard to prove that all these septic cases were the result of contamination by the examining finger, especially where proper technique was employed. With careless obstetricians, the dangers of infection would probably be increased by the rectal method of examination. He had been very glad to hear Dr. Willson's paper, and hoped that the work would be continued; it seemed to him, however, that it is not yet time to advocate the universal adoption of the method.

Dr. Willson expressed his appreciation of the kind remarks made in the discussion. He felt that, notwithstanding some of the remarks discounting the method, the very best authorities in this country are on his side; and if Whitridge Williams, with the superior environment of his clinic, feels that the best interests of his patients are subserved by employing this method then the rest of us may very well adopt it. It occurred to Dr. Willson during the discussion that in those cases of trial labor, there

being a doubt as to whether delivery may have to be accomplished by Caesarean section, when the section becomes necessary, it may be undertaken with an unsullied vagina, if the rectal method of examination has been employed.

FEEDING THE SICK, THE WELL, AND ECONOMICAL FEEDING.—ABSTRACT.*

By Philip S. Roy, M. D.,

Washington, D. C.

The history concerning the knowledge and beliefs pertaining to foods is very interesting. Paracelsus, in the 16th century, believed the stomach was controlled by a spirit who separated the good from the bad food. Lavoisier, in the 18th century, gave the first insight into the combustion of goods, which revolutionized the subject. Lavoisier lived at the time of the French Revolution, and the guillotine ended his brilliant life, which he asked to have spared two weeks to enable him to complete some experiments. During these troublous times he wrote: "Does it not seem a great injustice of Nature that the poor laborer uses more of his body substance, while superfluity, which is unnecessary for the rich, should be his portion?" Carl Voit, in the latter fourth of the 19th century, wrote the fundamental principles of nutrition, and since his time there have followed Chittenden, Benedict, Rosa, Atwater, Bryant, Rubner, Osborne, Lusk, Mendel, Folin, DuBois, and Abderhalden.

The final products of proteid assimilation, before being converted into tissue, are amino acids, whether the proteid is from beef, fish or vegetable, and the fish eater on Friday is eating the same proteid and purims as the beef eater and, like the man who will not eat pork, is not in touch with the light God gives us today.

Enough has been drawn from the writings of Mendel and others to make us feel the importance of knowing the proteid composition of foods, and how to mix them in order to obtain a sufficient quantity of complete proteid.

There are at least three fats that contain some principle that does promote growth—cod-liver oil fat, egg fat and butter fat.

Textbooks on feeding often contain the statement that fats can replace carbohydrates without any detriment to the body, and that carbohydrates can replace fats. In answer to this we quote from Mendel: "Without carbohydrate in the diet, the nutritive functions of a growing individual are menaced quite as

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readily as they are during adult life. Metabolism exhibits pathologic manifestations in the lack of carbohydrates." We find in one of the most widely-used textbooks on feeding the statement that eggs constitute a complete food. Eggs contain no carbohydrate. The inorganic constituents of the animal body are as important proximate principles as those we have already mentioned.

Harnsberger and others have recently called attention to the danger of demineralized foods—foods that by their process of manufacture have had removed from them many of their mineral constituents. But even with the proper mixture of fat, proteid, carbohydrate and salts, the body will not remain in a completely physiological state without the addition of certain other chemical substances, and although we know that their presence is necessary, their exact action in the body is yet in doubt. Funk has extracted from rice polishings a crystallized substance to which he gives the name of vitamine. He believes that it belongs to the group of pyrimidine compounds. So important a constituent of the body is this vitamine that nations living largely on polished rice, which is deprived of its vitamine by polishing, are subject to polyneuritis. Feeding unpolished rice cures the neuritis. There are other substances necessary to maintain perfect health—activators, and the products of internal secretion. Epinephrin, the active constituent of the suprarenal gland, is present in the blood only 1 to 100,000,000, yet it is essential to life.

Most of the digestion is in the small intestine. Many substances leave the stomach without any change at all, such as fats. Digestion in the stomach is influenced far more by the fat in the meat than by the kind of meat, and in stomach cases such diet as roast young turkey, quail, snipe, squab and other meats usually out of the reach of those in moderate circumstances is a fad. The only reason that can be given for prescribing these high-priced foods is that they may be most savory, and we all know that a juicy mouth makes a juicy stomach. The physical character of the food plays a very important part in its digestibility.

Raw milk has been so extensively discussed that nearly all dealers now are furnishing pasteurized milk. The handling of breads and other exposed food constitutes a source of incalculable danger. Vegetables and fruits often are laden with disease-bearing germs. Raw meats convey tapeworm, trichina and other parasites, and also bacterial infection.

One of the infections, Botulism, caused by the bacillus Botulinus, was for a long time supposed to grow only in meats, but has since been discovered in canned peas and beans. A true antitoxin has been made for this disease, and it is so important that we recognize this infection that some of its symptoms are here

given. The symptoms do not point at all to the gastrointestinal tract, but to the central nervous system. The muscles of the eye are early involved. Disturbance of accommodation, diplopia and strabismus occur. There is general muscular weakness. There may be dysphasia or epiphora, and there is usually great difficulty in swallowing. These symptoms gradually increase and death follows, unless the antitoxin is administered.

I have known headache and other symptoms of fatigue rapidly disappear with an increase of food and without the aid of drugs.

In time I believe the value of foods will be taught to children in school so that it will not be necessary to consult the physician in the matter of economical feeding. With the rapidly-rising prices of food products it is one of the most important economic questions. Snyder's Human Foods and their Nutritive Value, Gephart-Lusk's Analysis and Cost of Ready-to-Serve Foods and agricultural bulletins giving the cost of foods and their chemical composition, should be in every household.

A physician who does not know the caloric value of foods and their chemical composition can not intelligently feed the sick.

Since many observers have determined that digestive power in typhoid fever is within 85 or 90 per cent. of normal, it seems indeed strange that liberal feeding has been so slowly accepted. Often in the first week of typhoid fever there is some nausea which makes feeding rather difficult, but with a little encouragement on part of nurse and physician, even during this first week, a fair amount of both liquid and solid food can be given. After the nausea has disappeared both liquid and solid foods may be continued in more liberal quantities, and if the solid foods are properly prepared they do not cause distress. Typhoid fever patients do not have an appetite, but if we feed them liberally, particularly with solid food, we find that at feeding time a feeling of emptiness makes them willing to eat.

Some of the solid foods that we give in typhoid fever are bread, potatoes, rice, baked custard, tender meat minced, stewed meats, breakfast bacon, calf brains, baked apples, peaches and cream, ice cream, rice pudding, bread pudding, eggs in any form, etc.

Concerning the general opinion that the feeding of solid foods in typhoid fever causes irritation of any intestinal ulcer, with resulting hemorrhage, we feel certain that no such danger exists, and that the bleeding of ulcers in typhoid is often due to sloughing, following low vitality from under-feeding.

Dr. Williams had listened with great pleasure to Dr. Roy's very charming paper; it could be commended without reservation to the Public Instruction Committee for publication. Dr. Williams took exception to the statement that it was well known that the proteids occupy a more important position as heat producing

elements than fats and carbohydrates; this is a fact that is not very generally known. It should become known, however, because of the very great importance of such recent knowledge in the feeding of chronic diseases; and this applies particularly to nervous diseases. As to arterial hypertension, he had compiled a special diet for persons suffering from this condition; this diet does, however, contain tryptophan producing foods. The diet not only reduces pressure in most cases, but under it, functional activity improves, in spite of the theory that the pressure increase is necessary for the proper performance of function. There are a few cases though in which the pressure will not come down; and he was now trying a tryptophan free diet, after the suggestion of Eustace. Would Dr. Roy say whether tryptophan needs to be absent or only reduced to the Chittenden standard?

Dr. Mary Parsons understood Dr. Roy to say that the time is not far distant when the subject of food values will be taught in the schools. In that connection she would relate an experience with a school girl, a girl of thirteen, who had recently begun to menstruate and whose flow was rather copious; she went many squares to school each morning, but took no breakfast before going; she took with her a lunch consisting of an apple or an orange; her dinner consisted of a single potatoe, a lettuce salad, and bread and butter. The dietary was taken on the advice of her physical training teacher. Dr. Parsons' comments upon the dietetic advice were so pointed that she had no opportunity to see the girl again. It seems obvious that the teaching of food values in the public schools cannot be begun too soon.

Dr. Randolph said that it seemed to him that the general tone of Dr. Roy's interesting paper was too much in terms of "we now know," rather than in terms of "we now believe." Because recent investigations have led to the promulgation of new ideas, we are not yet able to say that our old beliefs are fallacious. Dr. Randolph had not gone into this subject as thoroughly as Dr. Roy evidently had, but many of the subjects touched upon had stirred reminiscent echoes, and Dr. Randolph could not help believing that we will have cause to retrace our steps in the matter of a good many metabolic doctrines, as we have been obliged to do in other fields. He did not wish to detract from the value of this paper, nor from the value of scientific research, but he did wish to advocate greater scientific humility.

Dr. Lochboehler said that it seemed to him that the subject narrowed down to the truth contained in the old German adage: "Man is what he eats."

Dr. Mallory thought that we ought all to appreciate the great value of Dr. Roy's labor in getting together the very rich material contained in the paper; heretofore, the subject matter has been very much scattered. An interesting observation of recent date not spoken of in the paper is that of Opie on the protection of the

organism against certain mineral poisons afforded by free carbohydrate feeding. The necessity of the protein portion of the ration and Chittenden's work on dietetic standards are well known; recently Abderhalden had been able to maintain a 150-pound man in nitrogen equilibrium by giving 130 grams of protein together with ammonium sulphate. It is possible that carbohydrates may combine with the ammonium radicle in amino-acids.

Dr. Mallory merely mentioned these observations as additions to the many suggestive facts usefully brought together in the paper.

Dr. Roy said that what effect tryptophan has on pressure he did not know; but the end putrefactive products of this substance are indol and skatol. Tyrosin is the substance that is particularly causative of pressure increase. In regard to Dr. Randolph's remarks, Dr. Roy thought that the facts cited in the paper had been pretty well determined as true by competent authorities.

A CASE OF BORACIC ACID POISONING.*

By Prentiss Willson, M. D.,

Washington, D. C.

On the 8th of September, 1915, baby S. was seven weeks and six days old. The baby, a girl, weighed five pounds and two ounces at birth. The labor was normal and only about ten days before the estimated date of confinement. The mother had been in splendid physical condition throughout pregnancy, and the small size of the baby could not be readily accounted for. It was breast fed, and at seven weeks weighed seven pounds and five ounces, a gain of over two pounds since birth.

On the date above mentioned the baby was given about three ounces of a saturated solution of boracic acid instead of boiled water. Shortly after this the baby was nursed, but vomited during the nursing, so that this was discontinued and three more ounces of the boracic acid solution were given. This was in the afternoon. In the evening the baby had many copious movements which soon became nothing but clear, jelly-like mucus. The vomiting and purging continued for about thirty-six hours, gradually decreasing in severity.

The day following the administration of the poison there was a little blood in the movements and once a considerable stain in the vomitus. The baby refused to nurse and rapidly lost weight. There was no fever. So far the picture was one of an acute gastro-enteritis of moderate severity, from a chemical irritant.

* Reported to the Medical Society October 20, 1915.

On the 10th the condition was much improved, vomiting and purging had ceased, and the baby was nursing well. At this time the mother called my attention to a slight miliary eruption on the neck, chest and back. On the 11th this had spread considerably and the epidermis seemed to have separated over small areas. By the following day a severe case of acute desquamative dermatitis, involving practically the whole body, was very evident. Dr. John A. Foote saw the case at this time and concurred in the diagnosis. The disease ran its course rapidly and the peeling was completed in about ten days. The baby rapidly regained a normal condition and now weighs eight pounds and four ounces. The skin seems to be perfectly normal.

I have called this case to the attention of the Society for two reasons. In the first place I have never seen such a case, nor have I found a doctor who has. The wife of one of my medical friends has told me of a case known to her, in which a baby was given one teaspoonful of powdered boracic acid in its bottle, instead of sugar of milk. The feeding was promptly vomited, the mistake discovered, and there were no further symptoms.

Boracic acid forms such an important item in the armamentarium of the mother of both breast and bottle-fed infants that it seems very possible that carelessness in its use may account for some of the otherwise inexplicable gastro-enteric attack of these little patients.

In the second place this case has served to crystalize and define a half-formed opinion which I have entertained for some time, that boracic acid solution is used with too lavish a hand in obstetric and pediatric practice. The saturated solution contains approximately five per cent. of the powdered drug. Remembering the liberality with which by the conscientious nurse and mother it is sopped on to the breast and into the baby's mouth before nursing, I do not believe it an overstatement to say that the baby may get one drachm of the solution in each twenty-four hours. This represents over two ounces of the pure drug in the first year of life. My case received altogether about one-quarter of an ounce in two doses.

The bactericidal properties of boracic acid solution as used on the breast and on the infant's mouth are probably practically *nil.* As such properties can be the only excuse for its use in this manner I have decided to do without it entirely, using as a substitute plain boiled water, which I believe accomplishes just as much, and without danger of insidious chronic action or of acute poisoning through mistakes or carelessness.

Dr. Barton said that this interesting case report contained matter of sufficient importance to warrant discussion for a few moments. He had never seen such a case; though cases of boric acid poisoning were not uncommon in the literature. Whether the reported cases had been in obstetric practice he did not know.

Most cases of boric acid poisoning had been in adults and had resulted from absorption when large amounts of the powdered drug had been applied to denuded surfaces in surgical dressings. Symptoms in boric acid poisoning, whether the poison was introduced by mouth or by absorption through the skin, were both local and general, but the most marked symptoms, as in Dr. Willson's case, were those of gastro-intestinal irritation. Dr. Barton agreed with Dr. Willson that the use of boric-acid solution in the care of infants had perhaps best be abandoned ; it did no good and as many regard it as innocuous, its dangers are thereby increased.

NITROUS OXIDE AND OXYGEN IN OBSTETRICS.*

By John Allan Talbott, M. D.,

Washington, D. C.

In presenting this short paper to the Society my object is to bring up for discussion the subject of Nitrous Oxide and Oxygen in obstetrical work, and to demonstrate the superiority of nitrous oxide and oxygen analgesia over other methods.

The disadvantages of the administration of chloroform, ether, or scopolamin and morphine in obstetrics are well known to all of us. With chloroform and ether, slowness in administration is the chief drawback. It is almost impossible to produce a stage of analgesia to the extent of affecting the actual physical pains of labor, and if pushed far enough to control pain they retard contraction, and in place of having analgesia we go a step further and produce anesthesia. I firmly believe that if nine-tenths of our obstetrical patients that have had chloroform or ether throughout the second stage of labor were questioned with regard to physical pain, we would find that the chloroform or ether, given a few drops at a time before each contraction, had little or no effect. I do not wish to imply that chloroform and ether have been entirely superseded by nitrous oxide and oxygen, but I do believe that nitrous oxide and oxygen cover a field in obstetrics that chloroform and ether do not reach, and in a few years will be as common in obstetrical work as they are today in dentistry.

Scopolamin and morphine have done much in relieving the physical pains of labor, but I think we are all agreed that this method can only be used in selected cases, preferably in institutions, and at the hands of experienced men. The wide publicity given to twilight sleep, both in the daily press and magazines and upon the lecture platform, has taught the thinking woman of

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today that the suffering she undergoes in labor is entirely unnecessary, and we are therefore called upon to devise a safe method of relieving this suffering. I believe that the use of nitrous oxide is the solution of this problem.

For the administration of nitrous oxide and oxygen it is not necessary to have an elaborate and expensive apparatus; simply a tube or two of gas and one of oxygen, connected by a rubber tubing with a gas bag, and this, in turn, connected with either a face mask, or a nose mask, such as that used in dentistry. For my personal use I have what is known as the Gatch machine, which is inexpensive, portable, practically indestructible, and has a mask that is readily sterilized. This mask covers the nose and mouth of the patient. The valves connected to the mask are very simple, and easily understood. By manipulation of these valves it is possible for the patient to breathe from the bag and exhale into the air. By closing the valves the patient can be made to breathe back and forth into the bag, the method known as rebreathing. By sliding the valve further back I can allow the patient to breathe only fresh air. This is a saving of oxygen, as the air quickly restores the patient when only analgesia has been maintained. Another advantage of the Gatch mask is that at any time during the course of labor, if for any reason operative interference becomes necessary, the patient may be completely anesthetized. The nose mask has not this advantage, as it does not cover the mouth. It is, however, probably more comfortable to the patient during analgesia.

As to the actual administration of nitrous oxide, first, gain the confidence of the patient by explaining that although the mask is to be fitted over her nose and mouth she can still breathe freely, and, after placing it in position, allow her to breathe fresh air in order to demonstrate that she will not suffocate. In order to obtain perfect analgesia it is important to instruct the patient to breathe deeply two or three times into the bag just before the contraction starts. After a few pains the patient generally knows a little beforehand when the contractions are beginning, or the hand placed upon the abdomen can feel the beginning contraction, and gas may be administered. If we wait until the contraction is under way the patient is either holding her breath or thrashing around, and it is impossible for the gas to take effect. If in the second stage, the patient should be instructed, after taking a few deep breaths, to bear down, or to pull on the sheet or strap provided for that purpose. Some patients require more nitrous oxide than others to produce analgesia, especially very nervous women, but in each individual case a few pains will instruct her as to how much gas must be used to be effective. After the contraction has passed off the valve may be slipped back and the patient breathes fresh air, or,

if for any reason you think she has gotten a little too much nitrous oxide—indicated by cyanosis—give her pure oxygen. It is well to only partly fill the bag; then, when the contraction passes off, the remaining gas may be saved for the next pain by clamping the tube leading from the bag. Between contractions the patient is told to absolutely relax, to breathe quietly and calmly until the next contraction is imminent, when the procedure is repeated.

The advantages of nitrous oxide and oxygen analgesia are as follows: The patient does not entirely lose consciousness during contractions and can therefore help materially with the expulsive pains; she is absolutely conscious between contractions; all nervous excitability is quieted. The gas actually prolongs and increases the force of the contractions by so relieving the physical suffering that the patient gets the full benefit of each contraction, and does not lose the force of the contractions by crying out; when the child is delivered, analgesia may be increased to anesthesia, thereby rendering the patient entirely unconscious of delivery; by administering oxygen the patient is brought back to consciousness while the cord is being tied, and may be again anesthetized if any suturing is necessary, or even for the sometimes very painful procedure of the delivery of the placenta. Finally, at the end of the third stage of labor, the mother may be given deep inhalations of oxygen, and she is then in full possession of all her faculties. The baby cries immediately upon birth.

Nitrous oxide may be given in all cases of obstetrics, no matter what the complications. I shall cite a few instances in which I have used it with complete satisfaction, and I might add here that my experience has been that multipara are better subjects than primipara. The change is so great to a woman who has had ether or chloroform in previous labors that she views the effect of the administration of nitrous oxide as miraculous, and in a good many instances it is hard to convince her that delivery has taken place. With primipara, on the other hand, we are dealing with a woman who is probably extremely nervous and excited, often frightened, and it is difficult to obtain her entire coöperation, and we find it necessary for the patient to coöperate thoroughly in order that the gas may be given at the proper time and in sufficient quantity. Some men with whom I have talked have stated that their objection to nitrous oxide is that it is difficult to accomplish any operative interference in which the hand has to pass within the uterus. It is true that I have had only a few cases in which version was done under nitrous oxide, but in these instances the operator experienced no difficulty, and the cases terminated satisfactorily. Another objection put forth is that nitrous oxide causes relaxation of the uterus with increased bleeding. My experience has been that it does not cause relaxation of the uterus with the attendant increased bleeding.

The chief disadvantage of nitrous oxide, and the only one that my experience with it has found, is the expense. My experience has been that depending of course upon the individual, it is necessary to use about one cylinder of nitrous oxide containing a hundred gallons to produce analgesia at each pain throughout the second stage of labor. This also covers the small amount of gas unavoidably wasted. These hundred-gallon cylinders cost $2.25. The oxygen in forty-gallon cylinders costs the same, and the amount consumed during the second stage of labor is about half a cylinder. You will therefore see that the actual cost of material is from three to three and a half dollars. These figures are given on small tanks of nitrous oxide and oxygen, as they are the only size that is really portable. Men who have figured the cost at from one and a half to two dollars have based their calculations on very large tanks that can be used only in hospital work, and are absolutely impracticable for carrying from place to place. I might explain this difference in figures by saying that the gas purchased in large tanks may be had at a much more reasonable price per gallon. To reiterate, the only objection which attaches to nitrous oxide is the expense, and this, unfortunately, places it beyond the reach of the poorer classes, unless they are delivered in institutions.

Personally I cannot agree with some men who have recently written on this subject, that it does not require a special training to give nitrous oxide and oxygen. It does not necessarily have to be a physician, but most certainly the person should be thoroughly trained in order to give nitrous oxide and oxygen in obstetrical work. After an experience of six years with nitrous oxide I agree entirely with Dr. Crile, of Cleveland, that it is one of the most difficult anaesthetics to administer, and should be given in surgical or obstetrical work only by those who have had special training.

To summarize, first, safety. I know, from personal experience and review of the literature, of no reported fatalities due to nitrous oxide in obstetrics. The number of cases in which it has been used is, of course, small as yet, as compared with chloroform and ether. Second, nitrous oxide will produce analgesia with certainty, not so chloroform and ether. And, third, nitrous oxide has no immediate or remote bad effects upon mother or child. Chloroform and ether both produce blood changes, and reduce resistance to infection. The only objection, as I have said, if it is an objection, is the cost.

In the following cases I shall not cite the many normal deliveries under nitrous oxide analgesia, but shall confine myself to such cases as presented complications. I might mention here that we have used nitrous oxide in all cases of Caesarean section for the past three or four years, and with brilliant results.

Case 1. April, 1912. Toxemia. Mrs. F., multipara, between eighth and ninth month. Version performed, and child delivered. Patient reacted promptly, but had slight fainting spell shortly afterward. Convalescence uneventful.

Case 2. May, 1912. Normal labor. Mrs. J., 28 years old, multipara. This patient, in view of severe pain at previous delivery, absolutely demanded some form of anesthesia. Analgesia was maintained for one hour. Contractions strong, prolonged, and delivery very rapid. This patient could hardly believe that her child had been brought into the world. Anesthesia for suturing perineum, and light analgesia for delivery of the placenta.

Case 3. January, 1913. Prolonged labor. Mrs. L. This patient had suffered so much physical pain that she was exhausted, and pains were slight and non-productive. Analgesia started. Contractions increased, were prolonged, and gained in volume. Woman delivered herself, although I had been called in order that forceps might be applied. In connection with this case I wish to say that I do not believe that nitrous oxide has so much influence on the actual contractions of the uterus, but it so relieves the physical pain of labor that, as I have said before, the woman gets the full benefit of each contraction.

Case 4. June, 1913. Mrs. M., primipara, highly nervous and inclined to be hysterical. Difficult to handle. Analgesia increased to anesthesia during the latter part of the second stage of labor. Pains expulsive in character. Child delivered naturally. Mother promptly reacted.

Case 5. March, 1914. Eclampsia. Mrs. S., 25 years old, primipara, full term. Edema marked, particularly of the labia and lower extremities. Caesarean section. Mother and baby both saved. Mother reacted immediately following operation. Convalescence uneventful. This was under anesthesia, not analgesia.

Case 6. April 17, 1915. Severe heart case. Aortic stenosis. Mrs. W., 24 years old. One premature delivery, five months, and one miscarriage, two months. Full term. Respiration labored and very rapid. Pulse 160, and irregular. Had been in labor ten hours. Nitrous oxide and oxygen administered for one hour before forceps delivery. Patient showed marked symptoms of shock several times during analgesia. Child did not breathe, although pulmotor was applied. Mother satisfactorily reacted.

Case 7. August 19, 1915. Rigid perineum. Mrs. F., multipara. Previous labors slow and very painful. Gas and oxygen throughout the second stage of labor. Anesthesia at time of delivery. Delivery natural. Perineal suture. Promptly reacted. Hard to convince, in view of past experiences, that child had been delivered.

Dr. A. L. Hunt was glad that such a paper had been presented; it was especially timely in view of the prevalent newspaper talk about *dammerschlaf*. We have in the method advocated by Dr. Talbott a good substitute for another which we cannot recommend. Dr. Hunt had no personal experience with twilight sleep, but one after another the best men are abandoning it. Anesthesia specialists in Chicago have been especially active in the use of nitrous oxid and oxygen in obstetrics. The object is to accomplish *eutochia* rather than *amnesia*. The advantages claimed for the method are ease, safety and availability. There are several forms of apparatus used to give the gas, but there is not very much choice between them. The type of inhaler is of some importance when one desires analgesia rather than anesthesia.

The nitrous oxid-oxygen mixture in obstetrics does not interfere with the consciousness of the patient nor with the strength of the pains. Some observers think that it shortens labor because the patients do not shrink from the pains and they are therefore more effective. The cost of the gas is the principal objection; this will average $3.00 per hour.

An additional advantage this method has over twilight sleep is that it does not interfere with aseptic technic. Some men have undertaken to employ it by self-administration; but the useful coöperation of the patient is thus lost. Others have used a foot-bellows apparatus operated by the accoucheur himself; but the assistance of a trained anesthetist is best. He had never noticed any difficulty in getting sufficient relaxation.

Dr. A. E. Pagan said that apparatus used by Dr. Talbott makes the mixture of gases depend upon the personal equation of the anesthetist. There are forms of apparatus which accurately standardize the mixture, and thus the amount of gas employed can be absolutely controlled. Physiologists say that nitrous oxid gas may be entirely disregarded as a source of danger to mother or child.

Dr. R. Y. Sullivan had seen Dr. Talbott do much of the work recounted in the paper; observation of his work and Dr. Sullivan's own experience with the method in obstetric work led him to believe that it constitutes a new chapter in the history of obstetrics, and he prophesied a great future for it. Webster, of Chicago, is the pioneer exponent of the method; he has employed it for twelve years and he advocates its application very early in labor. It is pleasant to think that we have in this combination a safe and readily available method to relieve childbearing of its terrors. One distinct advantage is the possibility of deepening anesthesia for the purpose of correcting faulty positions without retarding labor. We may also take advantage of this fact to make correct diagnosis during the course of labor.

He had recently been using the method in every case in his own practice where the party could afford it. The longest time required for its administration was three and a half hours. He had now a group of cases including normal labor, version, mid-forceps, and Caesarean section, both vaginal and abdominal. The method does not act so well in vaginal section, because it does not stop contractions of the uterus.

Dr. Talbott thanked those who had discussed the paper for their kind remarks. It is necessary to remember that it is not essential to produce anesthesia for thorough examination; analgesia is sufficient.

Dr. J. F. Moran asked how does Dr. Talbott account for the variability of the depth of anesthesia produced in different patients? Dr. Moran had had several cases in which the nitrous oxid had to be abandoned and ether substituted.

Dr. Talbott replied that it is necessary to have an experienced anesthetist in order to get uniform results. It is not necessary that the anesthetist be a physician; a nurse, if properly trained, may administer the gas very satisfactorily. The coöperation of the patient is also necessary to get the best results. He had brought down the apparatus that he exhibited because it was portable, and it is only a portable apparatus that is practicable for use outside an institution. The more complicated machines waste gas, are unnecessarily expensive, and are no more effective than the simple forms.

CASE OF AMPUTATION OF THE RIGHT UPPER EXTREMITY INCLUDING THE CLAVICLE, SCAPULA AND HUMERUS.*

By G. Tully Vaughan, M. D.,

Washington, D. C.

The patient was a man, age 33, born in Italy, merchant, under the care of Dr. Castelli, and gave a history of vague "rheumatic" pains in the upper part of the right arm for two years. No history of injury or venereal disease; Wassermann test negative. About three months ago the upper part of the arm began to enlarge and the pain became worse and more continuous. The x-ray showed a tumor on the external surface of the humerus just below the anatomical neck; the bone itself showed areas of rarefaction.

October 26 an interscapulo-thoracic amputation was done, disarticulating the clavicle at the sterno-clavicular joint; in cutting the brachial plexus, close observation failed to show any

* Reported with specimen to the Medical Society October 27, 1915.

evidence of shock attending or following the division of the nerves, although they had not been injected with an analgesic. The patient has done well and a week after the operation he had had no fever nor a pulse rate above 88.

I do not have the hopeless feeling as to a cure that some surgeons have in regard to operations for sarcoma, provided the operation is early and radical. I have a patient still living without recurrence, eighteen years after removal of the entire clavicle for round and spindle-celled sarcoma; also a man in this city whose thigh was amputated at the hipjoint fifteen years ago for round-celled sarcoma of the lower end of the femur; he still lives and with no signs of recurrence; and some other patients who, when last heard from, two or three years after operation, had no signs of recurrence. In the specimen presented here the sarcoma was partially encapsulated and of the large round-celled variety.

Dr. C. N. Chipman said that Dr. Vaughan had spoken of the absence of any change in the pulse rate in this case when the brachial plexus was cut. Dr. Chipman recently saw a case of breast amputation and other surgical work as palliative measures for extensive carcinoma; it became necessary to cut the brachial plexus, and he particularly observed the pulse, but was unable to detect any effect upon either rate or quality. There was no nerve blocking.

Dr. E. Castelli said that he first saw the patient about a week ago. The man had had pain in the shoulder for several years; it had been diagnosed as rheumatic. Dr. Castelli did no more than to ask for the x-ray picture; with that and the history, there was nothing else to suggest but osteo-sarcoma. The only diagnostic mistake was that he thought that the growth was medullary, in which case the prognosis is supposed to be better. It was found to be periosteal, but Dr. Vaughan does not think that the man's chances are reduced by this fact.

A CASE OF CONGENITAL VISCERAL SYPHILIS.*

By B. M. Randolph, M. D.,

Washington, D. C.

R. S., white, male, aged 16 years; first seen June 17, 1915. His father died at 35, of cerebral syphilis. Mother living, and in perfect health; has had only one child, and no miscarriages. Paternal grandmother is living, and has suffered for many years from extensive chronic ulcerations of the legs. She has had no physician, treating her condition herself.

* Reported to the Medical Society October 27, 1915.

The patient had diphtheria at the age of 22 months; measles and whooping cough later in childhood; keratitis at the age of 7, and again at 13; tonsils and adenoids removed two years ago. Was always delicate and underdeveloped.

His mother brought the boy for advice concerning an abdominal enlargement, which was brought to her attention by an insurance examiner a week previously. The patient complained of no pain, had regular bowels, variable appetite, and slept well. He helped his mother in her shop, and she had noticed recently that he was very languid and inattentive.

His skin was pallid, and of a muddy hue. The conjunctivae pale and dull. The visible mucous membranes paler than normal. The voice had a nasal quality. The teeth were poorly developed, and the upper median incisors showed a crescentic indentation along the cutting edge. Pulse 132, and of poor quality. Thorax emaciated, and the thoracic veins prominent. The heart was not enlarged, but its transverse projection was increased. No adventitious sounds. The second pulmonic sound was exaggerated. The lungs exhibited nothing abnormal. The abdomen was symmetrically enlarged throughout, smooth and firm, and dull everywhere to percussion. The dulness was continuous with that of the liver and spleen. No line of demarcation could be made out between the liver and spleen. The radiograph showed that the entire true abdominal cavity was filled with solid viscera. There was no ascites. General poor development and undernutrition of whole body.

Urine acid, sp. gr. 1.024; no albumen or sugar; sediment normal. Blood: haemoglobin 85 per cent., leucocytes 7,200; red cells 4,000,000; polymorphonuclears 62 per cent.; small lymphocytes 18 per cent.; large lymphocytes 19.5 per cent.; eosinophiles .5 per cent. The red cells showed some inequality in size and moderate irregularity of shape. The lymphocytes showed marked basic granular degenerative deposits in their protoplasm. The granules of the polymorphonuclear cells were much coarser than ordinarily. Wassermann double plus.

He was given six decigrams of neo-salvarsan intravenously. This was repeated two weeks later. This was followed by the intramuscular injection of .06 gram of mercury salicylate, suspended in oil of theobroma, once weekly for twelve weeks. Iodide of potassium was then given, beginning with .6 gram daily, and gradually increasing the dose, till 2 grams daily were given. This was continued five weeks.

His present weight is 107 pounds; an increase of 15 pounds. He has grown in height, amount not determined. Feels well and strong. There has been great diminution in the size of the enlarged viscera, though they have not yet returned to the normal limits. Oct. 1, 1915, the liver extended 6 cm. below the costal margin in the nipple line; the total vertical projection being

14.5 cm. The spleen extended 9 cm. below the costal margin, the total vertical projection being 13.5 cm. Wassermann plus, Oct. 22.

Dr. Prentiss Willson asked how could the transmission of syphilitic infection to the third generation be accounted for? Was the mother syphilitic?

Dr. J. T. Wolfe said that the case reminded him of one encountered in his own practice, but not of congenital origin. The woman, married at an early age, had been married eighteen years before symptoms appeared. She had a slight local sore after marriage, but no constitutional symptoms. She has had two children; a boy of fourteen is anaemic, has Hutchinson teeth and deformed ears; the girl, two years older, seems to be in good health. Two years ago this woman began to lose weight and to vomit persistently; her liver became enormously enlarged; the spleen was not affected. Under treatment, she entirely recovered. The husband had contracted syphilis five months before marriage.

Dr. W. H. Hough said that in very many cases of syphilis of the nervous system, no history of the acquisition of the disease can be obtained; the fact remains, however, that it is acquired syphilis that results in cerebro-spinal involvement in the great majority of cases over 25 years of age. As the father of the boy, in the case reported, had syphilis of the nervous system at the age of 38 years, the disease was probably acquired, in spite of lack of history of such an event; in that case, the boy does not differ from other instances of congenital syphilis of the second generation.

Captain M. A. Reasoner, U. S. Army, said that this was a most interesting case; syphilis of the liver is the most frequently found of the congenital manifestations as in this case. He was inclined to agree with Dr. Hough that the disease in the father was probably acquired. It is not necessary to assume that a spirochaete must be in the fertilizing spermatozoon in order to account for congenital syphilis, as the mother in the average case is already infected. The *treponema pallidum* has a genitropic action and tends to localize in the testicle from which it has been recovered when other gross lesions were absent. This is an interesting point in the transmission of the disease.

Dr. J. S. Wall said that Hutchinson teeth were indeed present in this boy, but this sign is not as characteristic as a peculiar degeneration of the 6th-year molars, which consists of a mulberry excrescence in the center of the grinding surface, surrounded by a decaying sulcus. In this case the sign cannot be demonstrated, but the significant fact may be seen that each 6th-year molar has been capped by the dentist. Children may easily deform the

incisors by trauma so that they resemble Hutchinson teeth, but the deformity of the 6th-year molars is pathognomonic.

Dr. Randolph was obliged to Capt. Reasoner for answering Dr. Willson's question; Dr. Randoph was not sure that he would have been able to do so. That this was an instance of transmission of syphilis to the third generation had not been made out, of course; the idea was merely suggested as an interesting possibility. The thing to do is to get the Wassermann reaction from both the mother and the grandmother. The changes in the teeth referred to by Dr. Wall are very interesting; Dr. Randolph had noticed the decay of the four 6th-year molars in this case. The boy has, however, typical Hutchinson teeth, and they were not made so by trauma.

In Memoriam.

DR. WARWICK EVANS.

Dr. Warwick Evans, who died at his residence, 1105 Ninth Street, Northwest, in this city, on the 30th of September, 1915, was in his 88th year, having been born in Portsmouth, N. H., on the 15th of September, 1828. He came to Washington in 1831, and lived here until the time of his death, so that he could be truly styled one of our oldest inhabitants.

Doctor Evans descended from a stock of honorable and sturdy New England pioneers. During the war of the Revolution his grandfather, John Evans, was one of the largest foreign merchants in New England, and lost many vessels as a result of the conflict. Dr. Evans' father, Estwich Evans, who was also born in Portsmouth, N. H., lived a long and eventful life. His travels through the western part of our country in 1818, he described in a book entitled "The Pedestrious Tour," a book replete with fine and elevated sentiments. A few years after the tour he sailed to Greece in a United States ship-of-the-line, to take part in the struggle against the Turks, and was the possessor of an autograph letter of Lafayette, eulogizing his efforts in the glorious cause of freedom. For many years he was a contributor to the *National Intelligencer*, and enjoyed the personal friendship of its editors, Messrs. Gales and Seaton. He died Nov. 20, 1866, aged 80 years.

Dr. Evans' mother, Eliza Wade Lemon Evans, was born in North Carolina; she died in Philadelphia Sept. 30, 1883, aged 82 years.

Dr. Evans' earlier years were passed in the cottage on Vine Terrace, where now stands "The Highlands" apartment house. There were seven acres in the plat, and the name was given because the land was terraced and planted in grapevines.

He married, Nov. 10, 1850, Mary Mason Washington, daughter of Lund Washington, the first postmaster of the Federal city.

He graduated in 1852 and enjoyed the distinction of holding the first diploma granted by the Medical School of Georgetown University.

He was elected a member of the Medical Association of this District April 7, 1863. The record states that "his name was announced to the Association, there was no objection, and the secretary was directed to record him as a member." He was elected a member of this Society Feb. 1, 1864, and was therefore a member over 51 years.

For some years, 1865–1873, he was Demonstrator of Anatomy at the Georgetown Medical School; Lecturer on Anatomy 1873–4, and Professor of Anatomy 1874–6. In this work he was greatly assisted by his devoted wife, who found time, in addition to her many domestic duties, to draw and color about 500 anatomical charts, which are still preserved, and some of which are really works of art.

To show the estimation in which he was held by his associates in those early days of his professional career, a newspaper clipping is reproduced.

"Presentation to Dr. W. Evans by his Alumni Associates.—A very pleasant affair occurred last night at the Medical Department of Georgetown University. The alumni of the college assembled at the close of Dr. Warwick Evans' lecture, and presented him, in the presence of the class, with a case of beautiful pocket instruments. Dr. Ralph Walsh, representing the alumni, made the presentation with the following remarks: 'Gentlemen, we are assembled for a very pleasant purpose. The Alumni Society of the Medical Department, Georgetown University, has long desired to express its esteem for Dr. Warwick Evans, and has been guided in the selection of a proper testimonial by the thought that usefulness would add to its value. Dr. Evans, in presenting you with this case of instruments, I must say that I am proud of the duty I have been called upon to perform. Knowing that words can add nothing to the high estimation in which you are held by a Society that for four consecutive years elected you to its highest office, I will simply ask you to accept this little token as proof that we have penetrated the veil of modesty that would hide rare professional abilities; that we appreciate the universal kindness and courtesy marking your public and private association with us, and that we have learned to love and esteem you for those qualities of mind and heart that make the cultivated and Christian gentleman.'"

Dr. Evans was evidently surprised by this friendly manifestation, but very happily replied as follows: "It is with feelings of deep emotion, as well as pride and pleasure, that I have listened to the sentiments that you have uttered in the presentation of

this really beautiful souvenir of friendship, which shall ever remain with me as a memento of dear friends, and happy hours, whose talismanic spell shall have power to cheer the heart amid the sad hours which come ever and anon to darken the spirits of the most sanguine and cheerful. I beg leave, sir, to return you, and through you to your associates, my heartfelt thanks for, and full appreciation of, the honor and flattering compliment conferred. To say, sir, that I am wholly surprised upon this felicitous occasion would be, perhaps, untrue, for, upon looking back to the winter of 1864–'65, when I first became officially connected with the institution of which we are a common offspring, then tracing the lapse of years down to the present time, I am conscious of having been the unworthy recipient of one unbroken chain of kindness and staunch friendship from the successive classes of the institution, among the alumni of which I number many of my warmest and most cherished friends. Why, then, sir, should I be surprised, when this is but another link in the golden chain which has so happily united us, and which, Heaven grant, may remain as now a perfect unity. Again thanking you and your associates for this renewed manifestation of your friendship, which I assure you I fully recognize and appreciate, and wishing you all prosperity and happiness, a ripe old age crowned with honor, and the love of your fellowmen, I bid you goodnight."

The occasion is one that will long be remembered by alumni and students as one of the brightest links in college history.

He was married twice. He had twelve children by his first wife, and there are 17 grandchildren and 22 greatgrandchildren now living. Following her death in 1899, he married, June 28, 1905, Miss Emma Tudor Demming of this city, who is now living. By his second wife he had one child who is now 7 years old.

The Doctor always enjoyed the best of health, and it was only within the past few months that increasing weakness began to interfere with his activities. About a month before his death his left leg became oedematous and there was evidently some pelvic obstruction, probably venous thrombosis. He did not take kindly to the suggestion of rest, and it was only during the last week that he consented to stay upstairs. The last few days there was considerable dyspnoea at times. A few minutes before death he arose and went to the closet; returning to his bed he was seized with an attack of orthopnoea and suddenly expired.

Your committee offers the following preamble and resolutions:

WHEREAS after a remarkably long and useful life Dr. Warwick Evans was gathered to his fathers;

Resolved, that the Medical Society of the District of Columbia notes with sorrow, that in the death of Doctor Evans it loses a man whose high ethical standards and professional ability were an honor to the profession; and the city, a citizen, worthy of the love and respect of the community;

Resolved, that these resolutions be spread upon the minutes of the Society and a copy be furnished to his family.*

B. G. Pool,
D. S. Lamb,
C. W. Franzoni.

Dr. Pool said: It was not my privilege to be intimately acquainted with Dr. Evans and I regret that I did not know him longer and better, for the more I was with him the more I learned to admire and respect him. I was first brought within the sphere of his influence in May, 1908, on the occasion of the birth of his little daughter, Virginia May Evans. I owed my introduction at that time to the good will of the late Dr. Thomas C. Smith. Since then Dr. Evans allowed me to assist him in quite a number of maternity cases. He was an example and an inspiration to younger men. When the winter night was dark and stormy and the driving wind and sleet made the pavements difficult and dangerous, we might expect an octogenarian to sit by his fireside and muse on the days of yore. Not so with Dr. Evans, however, whom I have met under like conditions and always found him bright and cheerful.

I think that he realized the gravity of his case, but his greatest fear was not death, but that he might be incapacitated for work, and he did not give up until the very last. For 63 years this earnest, busy, modest man performed unfalteringly and unostentatiously the arduous duties of an exacting profession, and it seemed almost as if he might go on indefinitely. But old Father Time, who oft in his sport allows us to believe that we are eluding his touch, finally placed his finger on the pulse of Dr. Evans, and the brave heart that for so long had beat so stout and true was stilled forever.

LEON L. FRIEDRICH.

Leon Ludolph Friedrich was born in Washington, D. C., September 3, 1857. He attended the public schools of the District of Columbia and the Academic Department of the Columbian (now George Washington) University, and was graduated in medicine from that university in 1881. After graduation he pursued the study of medicine at Vienna. On returning to his native city he contemplated specializing in Dermatology, but he heard the call of Internal Medicine, and remained its faithful and efficient devotee.

He had a lucrative practice, which he retained until his last illness. He died in the city of his birth on June 15, 1915.

Dr. Friedrich was a man of genial personality and of warm friendships.

*Adopted by the Medical Society October 27, 1915.

We read in Ecclesiasticus that gladness of heart is the life of a man. Dr. Friedrich caught the brightness of the dancing sunbeams and the fragrance of sweet-smelling flowers, and was made glad. Whether in health or in disease, he diffused the very air of gladness. He was glad, and the world in which he lived was glad because of his having lived in it.

Your committee moves the following:*

Be it resolved, That in the death of Dr. Leon L. Friedrich the Medical Society has lost an honored and esteemed member, whose death it deplores; and

Be it further resolved, That this report be recorded in the minutes of the Society, and that a copy of the same be transmitted to the bereaved family.

E. Y. DAVIDSON,
C. S. WHITE.

DR. VALENTINE McNALLY.

Your committee desires to place the following memorial on the records of the Medical Society.

Dr. Valentine McNally, whose death occurred on August 8, 1914, was born in Scotland, October 18, 1839. His father was a Presbyterian minister.

When quite a young man Dr. McNally came to Washington and entered the Quartermaster's Department of the United States Army.

After the Civil War he matriculated in the Medical Department of Georgetown College and was graduated in 1867; he also received the degree of A. M. in 1869, and that of LL. D. in 1889. The College of St. Xavier, N. Y., conferred the degree of LL. D. in 1886.

Dr. McNally was elected to the Medical Society on November 13, 1867, and was Corresponding Secretary in 1869.

For a number of years he was Chief Clerk of the Ordnance Bureau of the Army; in 1882 he was appointed Ordnance Storekeeper with the rank of Captain; passing through the several grades he was retired with the rank of Lieut. Colonel.

Dr. McNally did not continue in practice many years, but during these years he endeavored to instill into the minds of his patients: "The laborer is worthy of his hire," and to that end he made charges against everyone who sought his services, and collected his fees in due time.

On one occasion he rendered a bill to a minister whose family he had attended. The minister called on him and very vigorously expressed his indignation at having been charged for medical services which so many other members of the profession would

* Adopted by the Medical Society October 27, 1915.

eagerly render without charge. Dr. McNally very courteously said to him: "The bill is correct, but if you consider yourself unable to pay it, just let it go and seek other advice in the future." The bill was paid, the minister recognizing the logic of the situation; in any sickness in the family McNally was continued as the family physician.

Whatever task Dr. McNally undertook he carried to the end carefully and thoroughly.

A man of large heart, his charities were dispensed without ostentation. Even in the matter of his funeral he expressed the wish that the military would not be called upon to take part, as he thought the soldiers had enough to do without being paraded at the funerals of their officers.

Although Dr. McNally retained his membership in the Medical Society he rarely attended the meetings.

A gentleman of the old school, chivalrous to the last degree, he endeared himself to all whom he met by his courtesy and friendly ways.*

T. N. Vincent,
J. S. Wall,
J. D. Thomas.

PROCEEDINGS OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Wednesday, October 6, 1915.—The President, Dr. Frank Leech, presided; about 100 members present.

The Chair announced the death of Dr. Leon L. Friedrich, and appointed a memorial committee consisting of Drs. E. Y. Davidson, J. Ford Thompson and C. S. White. Announcement was also made of the death of Dr. Warwick Evans, and a memorial committee consisting of Drs. B. G. Pool, D. S. Lamb and C. W. Franzoni was appointed.

The Treasurer presented his report for the months of June, July, August and September, which showed Receipts, $1,133.43; Disbursed, $480.99.

The Chairman of the Executive Committee, Dr. Cook, reported that the committee had considered a resolution proposed by Dr. Heitmuller in the Spring, providing for an investigation of the salaries of medical officers of the District government; a carefully prepared and interesting report on this matter had been submitted to the committee by Dr. Heitmuller, and the committee offered this document as its report and recommended that it be printed in the Annals. Adopted. See page 307.

* Adopted by the Medical Society October 6, 1915.

Dr. S. S. Adams, for a committee on testimonial to Dr. Taber Johnson, reported that a dinner in honor of Dr. Johnson would be given late in October; the committee invited members to subscribe to the dinner, the subscription being $5.00.

The program committee was authorized to arrange with the Anthropological Society for a joint meeting to be held October 13.

A report prepared by Dr. Llewellin Eliot for a committee on memorial to Dr. Valentine McNally was read and ordered recorded. See page 345.

A letter from Edwin Smith, 1345 Pennsylvania Avenue, N. W., protesting against certain regulations of the Health Department relating to the vaccination of school children, was referred to the Executive Committee.

A letter from Dr. Tom A. Williams asking for the publication on the program cards of a resolution which he proposed to introduce October 13, was referred to the Executive Committee. The proposed resolution read as follows: "That the Public Instruction Committee be given the mandate to resume forthwith the publication in the newspapers of statements concerning Hygiene and Prophylaxis."

Dr. Millard F. Thompson announced his desire to test a treatment for chorea and requested the coöperation of physicians having cases of that disease under their care.

Capt. M. A. Reasoner, Medical Corps, U. S. Army, reported a case of congenital syphilis. Discussed by Drs. Hough, S. S. Adams and Reasoner. See page 301.

Dr. D. S. Lamb showed the following specimen: *Scarlet fever; desquamated cast* in one piece, from sides and sole of foot. From a young man who had four distinct attacks of the fever; one at 6 years, one at 10, one at 18 and the last at 20 years. The specimen was cast off in the third. In his last illness, in 1877, Dr. D. C. Patterson of this city attended him, and Drs. W. W. Johnston and J. Taber Johnson were in consultation. The patient died of acute peritonitis, due to a perforating ulcer of the ileum; the ileum was obstructed by adhesions, and the retained contents underwent changes that set up ulceration. Dr. Lamb made the necroscopy; besides the intestinal lesions, the heart was somewhat hypertrophied, the liver passively congested and the kidneys much contracted. If the patient had not died of the intestinal trouble it is probable that he would have died of the contracted kidneys. What the intestinal lesions had to do with the scarlet fever, if anything, is of course a question. The statement that he had had four attacks of the fever seems to be authentic; the family was in good social position and educated.

Dr. I. H. Lamb spoke of the different types of desquamation in scarlet fever. The variations in desquamation are very confusing to the practitioner, both as regards the time of peeling and

the character of the process. The exanthem of scarlatina is, of course, a true dermatitis, and flaky desquamation should more likely occur. As a matter of fact, branny and flaky exfoliation may occur among the different children of one family in the same epidemic.

Dr. H. H. Donnally read a paper with the title: Scarlet fever; morbidity, fatality and influence of age, sex, locality and season; with lantern illustrations. Discussed by Drs. Woodward, Nichols, M. F. Thompson, Wall, I. H. Lamb, Masterson, Frank Leech and Donnally. See page 297.

Wednesday, October 13.—The meeting was held jointly with the Washington Anthropological Society, and in the absence of the President of that body, President Frank Leech presided; about 150 persons present.

Dr. Ales Hrdlicka addressed the Societies upon: "The evolution of man in the light of recent discoveries; and its relation to medicine." Illustrated with lantern slides. Dr. W. P. Carr briefly discussed the communication and Dr. Hrdlicka closed the discussion. See page 304. A rising vote of thanks for his interesting and instructive address was adopted. See page 304.

Wednesday, October 20.—The President, Dr. Leech, presided; about 100 members present.

Dr. Tom A. Williams, for the Committee on Relief of Belgian Physicians, communicated a note from the Belgian Legation expressing thanks for surgical instruments collected and forwarded by the committee.

A letter from Dr. Joseph C. Bloodgood, Secretary of the American First Aid Conference, requesting the coöperation of the Society, was read and referred to the Executive Committee.

A letter from Joseph Gawler's Sons, requesting an opportunity to bring to the attention of members their facilities for the making of post-mortem examinations was read and referred to the Executive Committee.

The resignation of Dr. Rolla Camden was accepted.

Dr. Prentiss Willson reported a Case of Boracic Acid Poisoning. Discussed by Dr. Barton. See page 329.

Drs. Dunmire and Tom A. Williams reported Two Cases of Spastic Paralysis and exhibited the patients. Discussed by Drs. W. P. Carr, Randolph, Barton, Dunmire and Williams. See page 315.

Dr. P. S. Roy read the paper for the evening, entitled "Feeding the well, the sick and economical feeding." Discussed by Drs. Williams, Mary Parsons, Randolph, Lochboehler, Mallory and Roy. See page 325.

Wednesday, October 27.—Dr. Leech, the President, opened the meeting; about 117 members present.

Dr. B. G. Pool, for a Memorial Committee, read a biographical sketch of the late Dr. Warwick Evans and presented resolutions of respect to his memory. The report and resolutions were adopted. See page 341.

Dr. E. Y. Davidson, for a Memorial Committee, reported resolutions of respect to the memory of Dr. Leon L. Friedrich. The resolutions were adopted. See page 344.

A letter from Dr. James M. Barbour, transmitting a letter from the Commissioner of Internal Revenue for the District of Maryland, and his reply to the same, was read; it called attention to the ruling of the Commissioner that under certain circumstances physicians must state the diagnosis upon prescriptions for narcotic drugs, and requested some action by the Society in opposition to this ruling. Referred to the Executive Committee, with power to act.

The President having been called away, Vice-President Boswell took the chair.

The resignation from active membership of Dr. George vonP. Davis was accepted.

The Executive Committee was requested to consider the advisability of asking for police protection for automobiles belonging to members in attendance at the meetings.

Dr. B. M. Randolph reported a case of Visceral Syphilis of congenital origin, and exhibited the patient. Discussed by Drs. Prentiss, Willson, Wolfe, Hough, Reasoner, Wall, Motter and Randolph. See page 338.

Dr. Vaughan exhibited a specimen of the entire arm, with scapula and clavicle, removed for osteo-sarcoma of the humeral head; he briefly reported the history of the case. Discussed by Drs. Castelli and Chipman. See page 337.

Dr. J. A. Talbott read a paper entitled: "Nitrous oxid and oxygen in obstetrics." Discussed by Drs. Hunt, Pagan, Sullivan, Moran and Talbott. See page 331.

Dr. Llewellyn Eliot read a paper entitled: "Foreign bodies in the rectum."

Dr. D. S. Lamb exhibited two specimens of foreign bodies which had been removed from the rectum.

The latest Boston story is about a small child who fell out of a window. A kindhearted lady came hurrying up with the anxious question, "Dear, dear! How did you fall?"

The child looked up at the questioner and replied, in a voice choked with sobs, "Vertically, ma'am."—*Tit-Bits.*

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Editorial.

HISTORY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.—Price $1.00, with 25 cents added if delivered in this city or sent by mail. Address Dr. C. W. Franzoni, 605 I Street, N. W. The books are in the custody of Dr. D. S. Lamb, at the Army Medical Museum.

THE WASHINGTON MEDICAL ANNALS, the official organ of the Medical Society of the District of Columbia, issued the first of January, March, May, July, September and November, will publish gratuitously such information of a medical, surgical and sanitary character, changes in personnel, &c., of hospitals, dispensaries, medical schools, medical societies and other medical agencies, as would be useful and interesting to the members of the Society. Address the Chairman of the Committee on Publication, Dr. D. S. Lamb, 2114 Eighteenth St., N. W.

THE WASHINGTON MEDICAL ANNALS.—Back numbers.—Members of the Society who have back numbers of the ANNALS, and do not intend to preserve them, are requested to send them to the Chairman of the Publication Committee. Requests for such numbers are frequently received. Address Dr. D. S. Lamb, Army Medical Museum.

SPECIAL NOTICE.—Members of the Society whose biographical sketches were published in the History of the Society, are requested to send to the Chairman of the Historical Committee, Dr. D. S. Lamb, 2114 18th Street, N. W., any data that they would like to *add* to what was printed in the History. There is no restriction as to the extent or character of the data, provided only that they are personal.

Members who were related to or well acquainted with *deceased* members or those who *resigned* from the Society, are requested

to look over the sketches of those deceased or resigned, and send desirable data to the Chairman, as above.

Members who have joined the Society *since the publication* of the History, and whose names do not therefore appear therein, are similarly requested to send to the Chairman such personal data, corresponding in quantity and character to the sketches in the History. Attention is particularly desired to be paid to degrees conferred, the year and institution, when and by which conferred.

THE OTHER MEDICAL SOCIETIES OF THE DISTRICT OF COLUMBIA.

ALUMNI MEDICAL SOCIETY OF GEORGETOWN UNIVERSITY.—Active membership, 100; meets on the third Saturday of the month at the Medical School. Officers: J. A. Gannon, President; L. A. Martel and T. F. Lowe, Vice Presidents; C. I. Griffith, Recording Secretary; J. M. Moser, Corresponding Secretary; C. E. O'Connor, Treasurer.

CLINICAL SOCIETY.—Officers: F. L. Biscoe, President; W. J. Mallory, Vice President; E. P. Copeland, Secretary-Treasurer; Censors: L. A. Johnson and J. D. Thomas.

CLINICO-PATHOLOGICAL SOCIETY.—Active membership limited to 25. Inactive membership: those who have withdrawn from active membership after fifteen years. A limited honorary membership of eminent medical men. Meets on the first and third Tuesdays of the month from October to May, inclusive. Officers: President, G. Brown Miller; Vice Presidents, Loren Johnson and H. H. Kerr; Secretary and Treasurer, B. M. Randolph.

EMERGENCY HOSPITAL CLUB.—The club was organized early in 1915 by the members of the Staff of the Central Dispensary and Emergency Hospital. Meetings are held on the second Saturday of each month from September to May, inclusive, the officers are Ernest F. King, President; W. B. Carr, Vice President; D. W. Prentiss, Secretary and Treasurer.

FREEDMEN'S HOSPITAL MEDICAL SOCIETY.—Meets on the second Wednesday of each month from October to May, inclusive. Composed of physicians connected with the Staff of the Hospital and the Medical Faculty of Howard Medical School. E. A. Balloch, President; S. L. Carson, Vice President; C. A. Allen, Secretary-Treasurer.

GALEN SOCIETY of the District of Columbia.—Wm. H. Littlepage, President; Harry A. Ong, Secretary.

1915.	*Place.*	*Essayist.*
November 15	Dr. Henning, The Rochambeau.	Dr. Pfender.
December 20	Dr. Titus, 1730 M Street, N. W.	Clinical.

GEORGETOWN CLINICAL SOCIETY; twenty-five active members, limited to graduates of the Medical Department of Georgetown University. Meets at the University Club on the third Tuesday in the month. John Foote, President; J. Russell Verbrycke, Jr., Treasurer.

HIPPOCRATES SOCIETY, membership limited to 25, with voluntary retired members after 10 years, meets on the second Thursday of the month from October to May. Officers for the year: J. R. Verbrycke, Jr., President; C. A. Simpson, Secretary.

MEDICAL HISTORY CLUB of Washington, D. C.—Officers: President, Frank Baker; Vice President, H. W. Lawson; Secretary, F. J. Stockman; Executive Committee, J. H. Bryan, Howard Hume, W. J. Mallory and the Officers. Members: Truman Abbe, Frank Baker, W. C. Borden, Joseph H. Bryan, G. Wythe Cook, John Foote, F. H. Garrison, Howard Hume, H. W. Lawson, W. J. Mallory, John B. Nichols, P. S. Roy, F. J. Stockman, I. S. Stone, John D. Thomas, Wm. A. White.

Program 1915-1916.

Date.		*Essayist.*	*Host.*
November 27	Reil's Rhapsodien	Dr. White.	Dr. Borden, 2306 Tracy Place.
December 18	"Benjamin Rush"	Dr. Bryan.	Dr. Lawson, 1117 Vermont Ave.
January 29	"Coins and Medals in Medicine"	Dr. Mallory.	Dr. Hume, 1830 Jefferson Place.
February 26	"American Medicine of the Eighteenth Century"	Dr. Cook.	Dr. White, Government Hospital for Insane.
March 25	"Joseph Leidy"	Dr. Garrison	Dr. Stockman, 1122 Girard Street.
April 26	"The History of Body-snatching	Dr. Baker.	Medical Society of the District of Columbia.

MEDICAL AND SURGICAL SOCIETY of the District of Columbia.—President, John Dunlop; Vice President, H. H. Hazen; Secretary and Treasurer, L. Eliot; Asst. Secretary, L. C. Ecker; Executive Council, O. A. M. McKimmie, E. L. Morgan, L. Eliot, L. H. Reichelderfer and Ecker.

SOCIETY OF MEDICAL JURISPRUDENCE, Washington, D. C. —President, Dr. Wm. A. White; Vice President, R. Ross Perry; Secretary-Treasurer, Dr. D. P. Hickling. Meets on the second Monday of each month from October to June at University Club. Has from forty to fifty members.

SOCIETY OF OPHTHALMOLOGISTS AND OTOLOGISTS, Washington, D. C., meets the third Friday of each month from October until May, inclusive.

Officers: President, A. B. Bennett, Jr.; Vice President, A. H. Kimball; Secy.-Treasurer, Carl Henning, The Rochambeau.

Active members: A. B. Bennett, Jr., J. W. Burke, V. Dabney, W. T. Davis, L. S. Greene, C. M. Hammett, Carl Henning, E. B. Jones, A. H. Kimball, R. S. Lamb, F. B. Loring, O. A. M. McKimmie, W. B. Mason, M. E. Miller, Mead Moore, S. B. Muncaster, W. S. Newell, J. J. Richardson, E. G. Seibert, R. R. Walker, W. A. Wells.

Inactive members: J. H. Bryan, W. K. Butler, H. S. Dye, Wm. H. Fox, W. P. Malone, H. A. Polkinhorn, C. W. Richardson, D. K. Shute, W. H. Wilmer.

Schedule of Meetings—1915-1916.

	Residence of:	*Paper on Eye by:*	*Paper on Ear or Throat by:*
November	Dr. Mason	Dr. Loring	Dr. Wells.
December	Dr. Miller	Dr. Greene	Dr. Walker.
January	Dr. Loring	Dr. Muncaster	Dr. Miller.
February	Dr. Richardson	Dr. Hammett	Dr. Moore.
March	Dr. Seibert	Dr. Newell	Dr. Richardson.
April	Dr. Hammett	Dr. Seibert	Dr. Jones.
May	Dr. Wells		Business meeting.

Society for Mental Hygiene, District of Columbia.—Organized at the New Willard June 3, 1915. Temporary President, Dr. Wm. A. White; temporary Secretary, Dr. D. P. Hickling. Organizing Committee: Surgeon General Rupert Blue, U. S. P. H. S., Miss Julia C. Lathrop, and Drs. White, Hickling and Frank Leech. The object of the Society is to work for the conservation of mental health, the prevention of mental disease and deficiency, and improvement in the care and treatment of those suffering from nervous and mental disease and mental deficiency.

Society of Social Hygiene, Washington, D. C.—President, Surgeon General Stokes, U. S. Navy; Secretary, Lt. Col. J. R. Kean, U. S. Army, Surgeon General's Office. The Society has four committees, namely: Education, Venereal Diseases, Protection of Women and Children, and Psychopathology. Yearly dues, $1.00. Persons desiring to become members should address Col. Kean and state to which committee they wish to be assigned.

Therapeutic Society of the District of Columbia.—Meets at the G. W. School of Pharmacy, 808 I Street, N. W., on the first Saturday in each month. G. W. Latimer, President; A. P. Tibbets, Secretary.

Walter Reed Medical Society meets on the fourth Thursday of every other month, from September to May inclusive. Composed of physicians located in the eastern part of Washington. Officers: J. S. Arnold, President; H. R. Schreiber, Vice President; M. H. Prosperi, Secretary; N. E. Webb, Treasurer.

Washington Medical and Surgical Society.—President, N. D. Graham; Vice President, R. R. Walker; Secretary,

Walter Van Sweringen; Treasurer, F. E. Gibson; Curator and Librarian, E. H. Egbert; Executive Committee: L. H. Taylor, Chairman, G. S. Clark, G. S. Barnhart; Program and Auditing Committee: Wm. A. Jack, Jr., Chairman, J. R. Nevitt, Walter Van Sweringen; Membership Committee: F. E. Gibson, Chairman, Wm. P. Reeves, Caryl Burbank.

Program—1915.

Essayist.	*Date and Host.*	*To open Discussion.*
Dr. Taylor	November 22, Dr. Frankland	Dr. Burbank.
Dr. Van Sweringen	December 20, Dr. Gibson	Dr. Clark.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY.—President, J. F. Moran; Vice Presidents, G. B. Miller, Prentiss Willson; Secretary, Truman Abbe; Treasurer, D. W. Prentiss. Retired members—G. N. Acker, S. S. Adams, E. A. Balloch, J. W. Bovée, W. S. Bowen, W. P. Carr, G. Wythe Cook, M. F. Cuthbert, H. D. Fry, H. L. E. Johnson, J. T. Johnson, D. G. Lewis, A. R. Shands, E. E. Morse, Elmer Sothoron, J. Ford Thompson, John Van Rensselaer.

Program—1915.

Date.	*Essayist.*	*Reporters.*	*Host.*
December 10	John Foote	L. A. Martel C. S. White.	Dr. Riggles.

WASHINGTON SOCIETY OF NERVOUS AND MENTAL DISEASES.—President, Wm. H. Hough; Vice President, Bernard Glueck; Secretary, J. J. Madigan. The Society has a limited membership of thirty, but welcomes Physicans and Surgeons interested in Neurology and Psychiatry. Meets monthly on the third Thursday at the Cosmos Club or a member's residence.

WOMEN'S MEDICAL SOCIETY of the District of Columbia.—President, Sophie Nordhoff-Jung; Vice President, Emma Lootz Erving; Secretary and Treasurer, Martha M. B. Lyon; Corresponding Secretary, Mary Holmes.

THE SECRETARIES of the other Medical Societies of this District are reminded that the ANNALS will publish the schedules of their meetings.

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS.—The following amendments have been made since the publication in Volume XII, March, 1913.

Constitution.—Article V, Section 4, adopted Nov. 4, 1914: before the words "Due notice" on page 142, insert "No application for membership that is rejected or withdrawn shall be renewed until after two years from the time of its rejection or withdrawal."

Section 10, same article; adopted Jan. 7, 1914: for "two years" substitute "one year."

Article VI, Section 5, adopted Jan. 6, 1915: in the last line, for "two" substitute "three."

Article VIII, Section 2, page 148, 4th line from top: for the word "disorders" substitute the word "diseases."

By-Laws.—Article VIII, Section 9, page 153, adopted Jan. 7, 1914: No member of the Staff of any hospital receiving patients in private rooms shall attend such private patient sent to the hospital by a member of the Society, not a member of the Staff, unless specifically requested to do so by the attending physician.

Please note that the figures in Sections 7 and 8 of this article, instead of being 7 and 8 should be 5 and 6.

Brigadier General George M. Sternberg, U. S. Army, and an Honorary member of this Society, died in this city November 3d. The Society will take appropriate action.

Dr. T. A. Williams, 1705 N St., N. W., a committee on collecting instruments for Belgian Physicians, will be glad to receive any instruments that members of the Society can spare, however old such instruments may be. Kindly send to Dr. Williams or notify him that you can contribute them.

Belgian Scholarship Committee, Washington, D. C.—In consequence of the devastation of Belgian museums, libraries and universities, numerous worthy students, research workers and professors, many of them crippled for life, are interrupted in their important work. To the lovers of equity and to those who cherish education and admire Belgian integrity and heroism an opportunity is hereby given to assist in bringing to America worthy intellectual men and women for a temporary free enjoyment of the privileges of American institutions.

This committee has already received assurances from the George Washington University for the instruction of ten students in any of the departments of the University. It is highly probable that the committee will receive from other American institutions similar assurances.

It is proposed to raise a fund at once to defray the traveling expenses to and from Belgium and the cost of residence in Washington for a period of one year of the students or research workers which the George Washington University has already generously provided for. In the case of professors it is hoped that the subscriptions will be sufficiently liberal to provide for honorariums as well, thereby giving all the students in Washington the benefits of lectures by Belgian scholars.

It is estimated that from $20,000 to $25,000 will be needed in the work at once, and in the event of a surplus being accumulated, it is proposed to apply this to the recuperation of educational work in Belgium. This committee is a subcommittee of the Central Committee for the Belgian Relief Fund for Women and

Children and other noncombatants, and it is organized with the approval of his Excellency, the Minister from Belgium to the United States.

Please draw checks payable to Belgian Scholarship Committee, John Joy Edson, Treasurer, Washington Loan and Trust Building, Washington, D. C. Checks for any amount, large or small, are earnestly asked for.

Belgian Relief.—George W. Crile, of Cleveland, says: "When I was in Belgium I received first-hand information from a number of Belgian physicians concerning their plight. They are indeed in dire need, and there seems to be no way by which this need can be overcome until their land is restored to them again. The freemasonry of the medical profession so binds all medical men together that it seems to me that no appeal to doctors for the aid of their associates in Belgium can be in vain. We should all realize also that no single appeal can satisfy what is going to be a long continued need; that we must give now, later again, and still later, and so answer repeated appeals until later conditions may restore to the Belgians the wherewithal to aid themselves."

Dr. J. Riddle Goffe, of New York, says that in a letter just received from Dr. Jacobs, of Brussels, the latter summarizes the situation of our Belgian colleagues as follows:

1. Many doctors were killed, consequently the widows and orphans, deprived of everything, are without a home, without means, with nothing left. 2. All country doctors or those living in small towns are ruined by loss of every possession they had. 3. Doctors in large cities are ruined by commandeering, war levies, etc. 4. The largest part of Belgian population has become the prey of infectious diseases, epidemics, with a large infant mortality, etc. 6. Ruined civilian populations cannot pay for medical advice, consequently several physicians are compelled to work for nothing, others are obliged to undertake any labor for gain as a means of livelihood with results that are terrible for the population.

The opportunity is here created for the medical profession of the world to show the brotherly feeling which exists among them, and they can do this by helping with the necessary funds.

Gorgas Prize Medal.—To be awarded yearly for the paper which shows the most important advances in medicine or surgery, on a medical or medico-military subject, preference being given to papers on medico-military subjects. Only for papers of exceptionable value. Competition is open to medical officers of the Army, Medical Reserve Corps of the Army, and medical officers of the organized militia. The prize is given by the Association of the Medical Reserve Corps, U. S. Army, New York State Division. The Board of Award consists of three members of the Faculty of the Army Medical School appointed by the Sur-

geon General of the Army. The papers to be submitted by March 31st of each year, to the President of the Board of Award, Gorgas Prize Medal, Army Medical School, Washington. The award to be announced at the graduation exercises of the School May 31st.

FRATERNITAS MEDICORUM.—The Medical Brotherhood for the Furtherance of International Morality. (See *Science*, August 6, page 179.) Every physician may become a member; man or woman; no fee required, but in order to maintain the organization, distribute literature, &c., voluntary contributions are welcome. President, Dr. S. J. Meltzer, Rockefeller Institute, New York City. The first Secretary is Dr. Wm. J. Gies, Columbia University, New York; Treasurer, Dr. Robert T. Morris, Post Graduate Medical School. There are a number of Councillors, all of them well known physicians. Also a large number of Honorary Presidents, of whom the following are Washingtonians: Surgeon General Gorgas; Dr. Alice Hamilton of the Federal Bureau of Labor Statistics. Also an Advisory Committee, including Dr. Alsberg of the Bureau of Chemistry, Dept. Agriculture, Dr. Anderson of the Hygienic Laboratory and Dr. Garrison of the Surgeon General's Library.

A committee of physicians and medical investigators request every physician to enroll as a member and declare his or her willingness to endorse and support the moral standard which the medical profession upholds when called on to perform its patriotic duties in an international strife. All communications should be addressed to Dr. Meltzer, 13 West 121st Street, New York City.

VITAL CONSERVATION.—A movement is afoot to form a society during the coming winter on what is termed "Vital Conservation." Letters from Dr. Gustavus Werber of this Society explain the object of the movement.

MEDICAL CORPS, U. S. NAVY.—Examination for admission to the Corps, November 15. For further information address the Surgeon General, U. S. Navy, Navy Dept., Washington.

NEW YORK SKIN AND CANCER HOSPITAL, Second Avenue and 19th street, N. Y. City. Dr. L. Duncan Bulkley, assisted by the Attending Staff, will give a series of clinical lectures on Diseases of the Skin, in the Out-Patient Hall of the Hospital, on Wednesday afternoons at 4:15 o'clock, beginning Nov. 3d. The lectures are free to the Medical Profession on presenting their professional cards.

THE U. S. PUBLIC HEALTH SERVICE issues various publications, each having a specific purpose. The annual report of the Surgeon General undertakes to detail to Congress, and through it to the citizens of the United States, what has been accomplished with the funds which they have appropriated for the Public

Health Service, and to outline plans for the future. The bulletins of the Hygienic Laboratory are intended for the technical professional reader. The Public Health Bulletins deal in a more popular way with public health subjects. The Public Health Reports are a weekly resumè of sanitary conditions throughout the world. The *Health News* attempts to present to the busy reader through the medium of the newspapers, short, pithy articles on personal hygiene and public sanitation. In order that the *Health News* may accomplish this, it is necessary that the Service have the coöperation of the press throughout the country. Suggestions as to timely articles will be appreciated. The Public Health Service believes that the only way to effect permanent sanitary betterment throughout the United States is by the inculcation of the sanitary habit on the American people. This is not only practical and economical but it is also in keeping with the basic principles upon which our form of government rests.

The National Society of Keep Wells.—We are asked to publish the following: "The National Society of Keep Wells, in inviting prominent physicians of Washington to talk before it, practically says: 'Doctor, we want you to tell the people how to keep away from you, just what to do to avoid the necessity of coming to you or to other doctors in your specialty. This is carrying out one of the fundamental ideals of the medical profession, which is to do away with itself, so that eventually there will be little or no need of physicians.'

"To spread this ideal of the medical profession among the people is also one of the objects of the Natianal Society of Keep Wells, and it is hoped by the example set in Washington similar organizations in cities and villages throughout the United States will invite their practicing physicians to tell their communities how to avoid sending for the doctor.

"It is the purpose of the society to publish in popular form the familiar talks before it, so that its influence may be more extensive and permanent.

"The officers of the society are: Mrs. Arthur MacDonald, president; Mrs. Mary Stevens Beall, secretary, and Miss Dorothy Dent, treasurer."

The American Society for the Study of Alcohol and Other Narcotics, will hold its 45th annual meeting at Washington, D. C., Dec. 15 and 16, 1915. This was the first society of medical men in the world, to take up the scientific study of alcohol and other narcotics. Its papers and transactions have been published in the *Journal of Inebriety*, and comprise the first scientific literature on this subject. Thirty-one papers will be read at this meeting by specialists and distinguished medical and scientific men. These studies will be confined exclusively to

the effects of alcohol on the brain and body, based on laboratory and clinical observation and experience. Programs can be had by addressing the Secretary, Dr. T. D. Crothers, Hartford, Conn.

NATIONAL ACADEMY OF SCIENCES.—The Academy recently began to publish a *monthly* of its Proceedings. This means that in the monthly will appear papers that describe "the first announcement of new advances," in any and all branches of science. The Academy is the natural representative of American research; this fact gives an authoritative standing to its publications. Papers will be received both from members of the Academy and also non-members, but papers from the latter must be sent through members. These papers thus published will reach foreign periodicals. It is not intended to publish papers *in extenso*, which are presumed to be so published in special or general publications, but something more than mere abstracts. For further information address Prof. A. A. Noyes, Chairman Board of Editors, Massachusetts Institute of Technology, Boston, Mass.

AMERICAN FIRST AID CONFERENCE.—Officers: Surgeon General Wm. C. Gorgas, Chairman; Secretary, Dr. Joseph C. Bloodgood, Baltimore, Md.; also Vice Chairman, Treasurer and Committees. The first meeting was held in Washington, August 23 and 24, 1915, at which the following resolution was adopted: "That this Conference recommends to the President of the United States that he appoint a Board on First Aid Standardization, said Board to consist of one officer each from the Medical Corps of the U. S. Army, the Medical Corps of the U. S. Navy, the U. S. Public Health Service, the American National Red Cross, the American Medical Association, the American Surgical Association, and the Association of Railway Chief Surgeons of America; this Board to deliberate carefully on first aid methods, packages, equipment and instruction, and to recommend a standard for each to a subsequent session of this Conference to be called by the Permanent Chairman; the creation and maintenance of the said Board to be without expense to the United States."

POST MORTEM EXAMINATIONS.—Examinations post mortem are often desired where however the facilities for making them are wanting. The Funeral Directors to some extent have provided such facilities at their establishments. Among the number the firm of Joseph Gawler's Sons has written to the Editor that it will afford the service to physicians, without charge either to the physician or family, and whether or not the firm is the Funeral Director. The necessary instruments are kept ready for use. In the absence of satisfactory arrangements otherwise, it is suggested that the offer of this firm be considered.

REVIEWS.

FRACTURES AND DISLOCATIONS. By MILLER E. PRESTON, A. B., M. D. Price, $6.50. St. Louis, C. V. MOSBY CO., 1915.

In reviewing a work on this subject one naturally seeks first for the author's views on the open treatment of fractures, since in this branch of surgery lately zeal has vastly outrun discretion. It is gratifying to note that the author takes an eminently sane and conservative position in the matter. Space will not permit of a full discussion of his views, but the following quotation will give a good idea of his position. He says: "The question of when and when not to operate in a given case depends upon the general condition of the patient and the degree of reduction which is possible by non-operative methods. * * * If the general health of a patient allows of an operation the question then arises, 'Can an equally good result be obtained by the nonoperative method as is possible with open treatment?' and secondly, 'Are the proper surgical surroundings and skill available?'"

The book is illustrated lavishly with original photographs, taken, for the most part, within a short time after the occurrence of the injury. These add greatly to the value of the text. No space is wasted in the elaborate discussion of rare and unimportant fractures, but, very properly, the more common fractures are carefully and thoroughly explained and discussed and the best methods of treatment indicated.

Being the latest work on the subject this volume contains an exhaustive account of the most recent procedures in autogenous bone grafting, including the work of Albee and Murphy in this field.

Fractures and dislocations are discussed together with satisfactory results and a great saving of space.

The chapter on the use of the x-ray, by Dr. H. G. Stover, contains a full description of the manner of use and the value of this very important aid in this branch of surgery. Very properly, Dr. Stover insists that the x-ray is not meant in any way to supersede the careful clinical and manual examination of fractures but to supplement them.

The book may be commended as one of the best in its line; in no way inferior to Stimson or Scudder, and in many ways superior to these well-known works. Anyone needing a safe guide in this most difficult branch of surgery will not go amiss in selecting this book as his *vade mecum*.—EDWARD A. BALLOCH.

OPERATIVE GYNECOLOGY. By HARRY STURGEON CROSSEN, St. Louis, Mo. C. V. MOSBY CO., St. Louis, Publishers. Price, $7.50.

We are pleased to announce the appearance of a book which represents the best of American Gynecological practice. In every

respect the work compares favorably with any predecessor and will prove as satisfactory as those produced by foreign authors. The greater part of the illustrations are admirable. The arrangement of the subject matter is satisfactory and nothing seems to have been left undone to render the teaching clear and easily understood by any one qualified to practice gynecology.

While we commend the production as a whole, especially its splendid illustrations and clear descriptions, it would be impossible for us not to find many statements in the text with which we cannot agree. The discussion of these subjects would lead us too far afield for the space allotted a review in the ANNALS, and moreover the distinguished author has perhaps as many agreeing with him as those who do not. The addition of "Medico-legal points," "Persistence of symptoms after operation," "How much should we promise our patients," are headings which permit Dr. Crossen to give sound advice such as is not often found in a scientific treatise.

We note with great interest and some apprehension the article regarding "Chronic Salpingitis" (p. 393), where we must emphatically differ with Dr. Crossen when he says: "The ovary also, is usually so much involved in the inflammatory process that it must be removed." It would be a sad commentary upon gynecological practice if, after fifty years of experience, such an apparently radical statement should represent the views of a majority of surgeons. We hope that Dr. Crossen may soon come to think with those who (like the writer) believe, and know, that a very large majority of women with chronic salpingitis need not lose both ovaries, and indeed it is in our opinion exceptional that double oophorectomy is necessary.—I. S. STONE.

RECENT PUBLICATIONS BY PHYSICIANS OF THE DISTRICT OF COLUMBIA.

J. F. Anderson; Post-vaccination tetanus; Reprint 289 from Public Health Reports, July 16.

J. F. Anderson and M. H. Neill; Blood picture of healthy Rhesus mōnkey; *Jour. Med. Research,* September.

C. E. Banks, P. H. S.; Veneral disease; its probable prevalence; Public Health Reports, Feb. 26; abstracted in *West Va. Med. Jour.,* October, page 141. Also in *Southern Med. Jour.,* September, page 761.

N. P. Barnes; Pedalion trained in terpsichorean festivities; abstracted in *Pacific Med. Jour.,* September, page 535.

W. M. Barton; Removal by caffein of some digitalis arrhythmias; *Amer. Jour. Med. Sci.,* September; abstracted in *Jour. A. M. A.,* Sept. 18, page 1056. Also, Non-technical differentia-

tion of cardiac arrhythmias; *Southern Med. Jour.,* January, page 20.

E. M. Blackwell, U. S. N.; An ambulance motor boat for hospital ships; U. S. Naval Med. Bull., October, page 637.

W. C. Borden; Pericolic adhesions; *Va. Med. Semi-Mo.,* Sept. 10, page 261.

J. G. B. Bulloch; Drugs needed in the practice of medicine; *West. Med. Times,* November, page 203.

W. M. Clark; Final hydrogen ion concentrations of cultures of bacillus coli; *Jour. Biolog. Chem.,* August.

G. W. Cook; The history of medical ethics; *N. Y. Med. Jour.,* Jan. 23; abstracted in *Southern Med. Jour.,* September, page 780.

V. Dabney; True myxoma of the rhinopharynx, report of two cases; *Louisville, Mo., Jour. Med. and Sur.,* October, page 151.

C. B. Davenport; Feebly inhibited, violent temper and its inheritance; *Jour. Nerv. and Ment. Dis.,* September; abstracted in *Jour. A. M. A.,* Oct. 9, page 1309.

C. R. Dufour; Trachoma; *Southern Med. Jour.,* September, page 816.

W. E. Eaton, U. S. N.; The present status of the Hospital Corps; U. S. Naval Med. Bull., October, page 556. Also, An unusually severe case of urticaria; *ibid.,* page 650.

L. C. Ecker; Case of aneurism of aorta; *Va. Med. Semi-Mo.,* Sept. 10, page 276.

L. Eliot; Neuralgia of rectum; same jour., August 27, page 253.

J. R. Ernst; Prophylaxis in dementia praecox and other psychoses; *Med. Record,* N. Y., Sept. 11.

A. M. Fauntleroy, U. S. N.; Shock, anoci association and anaesthesia; *Va. Med. Semi-Mo.,* Aug. 27, page 244; Sept. 10, page 269, and Sept. 24, page 295.

A. D. Foster, P. H. S.; Interstate migration of tuberculous persons; Public Health Reports, May 12; abstracted in *Southern Med. Jour.,* October, page 855.

C. B. Foster, Jr.; Endemic typhus in Philippine Islands; *Arch. Intern. Med.,* September.

Edward Francis, P. H. S.; Practical method of embalming on shipboard; *Military Surg.,* February; abstracted in *Southern Med. Jour.,* October, page 856.

L. C. Frank; Sewage disinfection for vessels and railway coaches; Public Health Reports, Jan. 1; abstracted in *Southern Med. Jour.,* September, page 760.

R. Gesell; Effects of change in auricular tone and amplitude of auricular systole on ventricular output; *Amer. Jour. Physiol.,* September.

M. H. Givens; Modification of Rose's method for the estimation of pepsin; Hygienic Lab., Bull. 101, August.

R. Glueck; Godman or Jehovah complex; *N. Y. Med. Jour.*, Sept. 4.

Joseph Goldberger, C. L. Williams and F. W. Hachtel; Report of an investigation of diphtheria carriers; Hygienic Lab., Bull. 101, August.

W. C. Gorgas; Report on the sanitation of Guayaquil; *Southern Med. Jour.*, November, page 925.

W. J. Harris; Importance of vital statistics legislation in the South; same Jour., October, page 834.

H. E. Hasseltine; The sterilization of dental instruments; Hygienic Lab., Bull. 101, August. Also, The practical use of disinfectants; Reprint 287, Public Health Reports, July 9.

H. H. Hazen; Case of leprosy; *Va. Med. Semi-Mo.*, Sept. 10, page 278. Also, Cutaneous cancer of the extremities; *Jour. A. M. A.*, Sept. 4, page 837. Also, Spinocelled cancer of skin; *Jour. Cutan. Dis.*, September; Abstracted in *Jour. A. M. A.*, Oct. 16, page 1407.

L. W. Johnson, U. S. N.; Injury by dynamite explosion. Also, Case of hemorrhagic pancreatitis; U. S. Naval Med. Bull., October, pp. 643–4.

J. T. Kelley; Appendicitis in pregnancy; *Va. Med. Semi-Mo.*, Aug. 27, page 240.

H. H. Kerr; Transfusion, its indications and limitations; same jour., Sept. 24, page 301.

J. W. Kerr, P. H. S.; The trachoma problem; Reprint No. 296 from Public Health Reports, Aug. 20. Also, The need of full time health officers; *Jour. A. M. A.*, Nov. 6, page 1595.

J. J. Kinyoun; Uhlenhuth's method of sputum examination for tubercle bacilli; *Amer. Jour. Pub. Health,* September.

Arthur MacDonald; How to avoid dangers of war; *Pacific Med. Jour.*, September, page 551.

Med. and Surg. Society, D. C.; *Va. Med. Semi-Mo.*, Aug. 27, page 254, and Sept. 10, page 278.

J. R. Nevitt; Case of acute articular rheumatism; same jour., Sept. 10, page 279.

J. A. Nydegger, P. H. S.; School hygiene; survey of schools in Manatee Co., Florida; Supplement No. 25, Pub. Hlth. Reports, July 30.

J. H. Oakley; Medical inspection of immigrants; *Lancet-Clinic,* September.

J. F. A. Pfeiffer; Case of chronic progressive chorea; *Amer. Jour. Insanity,* January; abstracted in *Southern Med. Jour.*, September, page 729.

E. C. Prentiss; A suggestion with regard to the medical treatment of cancer; *New Mex. Med. Jour.*, September.

B. M. Randolph; Clinical notes on tuberculous immunity; *Southern Med. Jour.*, September, page 762. Also, Case of throm-

bosis of coronary artery; WASH. MED. ANNALS, September, page 281; abstracted in *Buffalo Med. Jour.*, October, page 118.

L. H. Reichelderfer; Case of extra-uterine pregnancy; *Va. Med. Semi-Mo.*, Sept. 10, page 278.

E. W. Reisinger; The teaching of anatomy; same jour., Oct. 22, page 353.

T. W. Richards; Early reinfection with syphilis; U. S. Naval Med. Bull., October, page 651.

W. C. Rucker; Geographic distribution of plague and its menace to the United States; *Texas State Med. Jour.*, September.

E. Sachs; Intracranial telangiectasis, symptomatology and treatment; report of two cases; *Amer. Jour. Med. Sci.*, October.

Atherton Seidell; The excretion of thymol in the urine; Hygienic Lab., Bull. 101, August.

J. H. Selby; Metastatic carcinoma; *Va. Med. Semi-Mo.*, Sept. 10, page 279.

C. A. Simpson; Roentgen ray treatment of exophthalmic goiter; *Med. Record, N. Y.*, Sept. 4.

F. J. Smith; Case of typhoid fever; *Va. Med. Semi-Mo.*, Sept. 10, page 279.

F. W. Southworth and L. W. Johnson; Requirements of modern contagious diseases hospitals; *Modern Hospital*, October.

C. W. Stiles; Intestinal infections; Reprint No. 288 from Pub. Hlth. Reports, July 9.

A. M. Stimson, P. H. S.; Complement fixation in tuberculosis; Hygienic Lab., Bull. 101, August.

G. L. Streeter; Development of venous sinuses of dura mater in human embryo; *Amer. Jour. Anat.*, September.

E. A. Sweet; Interstate migration of tuberculous persons; Reprint 269 from Pub. Hlth. Reports; abstracted in *Buffalo Med. Jour.*, October, page 161.

J. L. Thompson; Acute diffuse pulmonary oedema; *Va. Med. Semi-Mo.*, Sept. 24, page 287.

C. H. T. Townsend; Two years' investigation in Peru of Verruga and its insect transmission; *Amer. Jour. Trop. Dis.*, July.

J. Weinzire and M. V. Velder; Bacteriological method for determining manural pollution of milk; *Amer. Jour. Pub. Hlth.*, September.

B. S. Warren; Sickness increase, its relation to public health and the common welfare; Pub. Hlth. Reports, Jan. 8; abstracted in *Southern Med. Jour.*, October, page 857.

M. J. White; Pellagra and uncinaria disease in relation to life insurance; *Lancet-Clinic*, October 9.

M. I. Wilbert; The pharmacy of useful drugs; Reprint 297 from Pub. Hlth. Reports, August 27.

H. W. Wiley; The importance of mouth hygiene to the gen-

eral health; *Amer. Jour. Pub. Hlth.,* May, page 412; abstracted in *Southern Med. Jour.,* November, page 939.

Oscar Wilkinson; The treatment of otitis media acuta; *Va. Med. Semi-Mo.,* Sept. 24, page 292.

T. A. Williams; Compensation for traumatic neuroses; *St. Paul Med. Jour.,* September, page 613. Also, Epilepsy in young adults and adolescents with reference to a new treatment based upon pathogenesis; *Pacific Med. Jour.,* September, page 557. Also, Principles and methods which result in intellectual precocity; *Lancet-Clinic,* Oct. 9.

PERSONAL NOTES.

Dr. J. F. Anderson has resigned from the Public Health Service and from the Hygienic Laboratory. He was elected President of the American Public Health Association that met at Rochester, N. Y., September 10.

Dr. L. J. Battle, Chairman of the Medical Committee of the G. A. R. Encampment in September last, was given a banquet by his colleagues of the committee at the Hotel Varnum, Oct. 7th.

Dr. Harry A. Bishop was married Oct. 6th at Fort Wright, N. Y., to Miss Roberta Carson Morgan.

Dr. E. M. Blackwell, U. S. N., has been transferred to the Steamer *Solace.*

Surgeon General Rupert Blue, P. H. S., is a member of the Executive Committee of the First Aid and Accident Society.

Drs. J. M. Cabell, J. L. Riggles and C. S. White are conducting an Army and Navy Quiz; persons interested should address Dr. Cabell, at 1730 M St. N. W.

Dr. A. B. Clifford, U. S. N., has been transferred from the Naval Medical School to the Steamer *Washington.*

Dr. H. H. Donnally read a paper, October 14, before the Pediatric Section of the New York Academy of Medicine, on the Morbidity and Mortality of Scarlet Fever.

Dr. F. H. Garrison read a paper on Leonardo da Vinci before the Chicago Society of Medical History, October 13th.

Surgeon General W. C. Gorgas, U. S. A., is President of the First Aid and Accident Society. He was also elected an honorary member of the American Public Health Association, at the meeting at Rochester.

Dr. J. W. Hart, M. R. C., U. S. A., has been ordered to active duty at the Washington Barracks.

Dr. Clarence S. Kitcham of this city was married, September 11th, at Huntingdon, L. I., to Miss Elizabeth Weed Rogers.

Colonel L. A. LaGarde read a paper before the Delaware State

Medical Society at the meeting at Wilmington, October 11 and 12, on Preparedness in relation to the medical man.

Dr. Wm. McCoy, P. H. S., has been appointed Director of the Hygienic Laboratory, in place of Dr. Anderson, resigned.

Dr. W. D. McKim was married, October 18th, in New York city, to Miss Leonora Jackson.

Dr. J. H. Selby attended the meeting of the American Roentgen Ray Society at Atlantic City, September 22 to 25, and took part in the discussion on Cystoscopy and Pyelography.

Dr. G. C. Smith, U. S. N., has been ordered to duty at the Bureau of Medicine and Surgery, Navy Department.

DINNER TO DR. JOSEPH TABER JOHNSON.

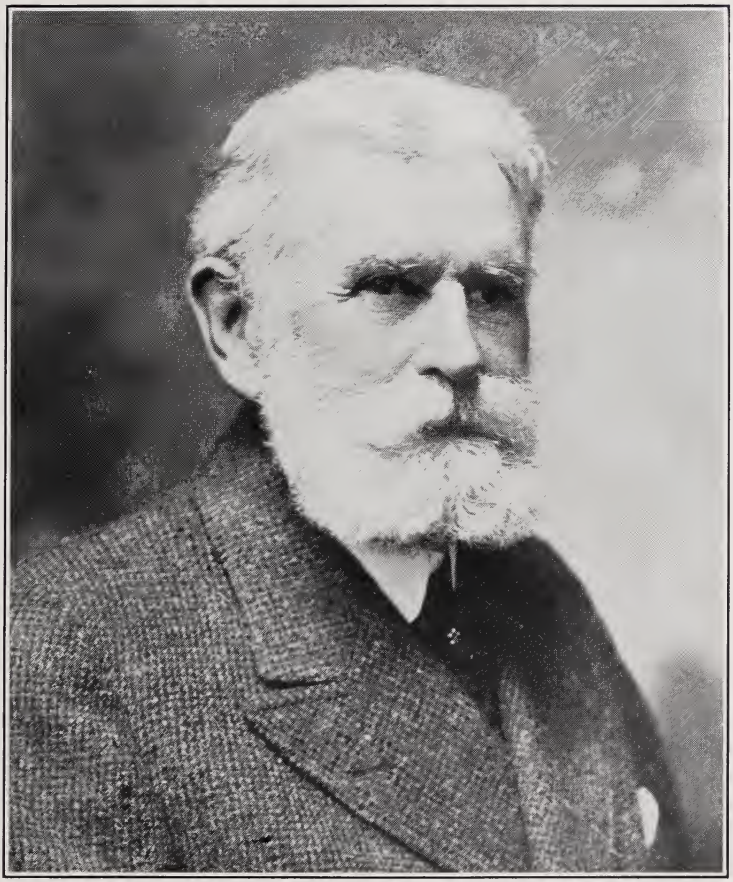
On the evening of October 28, at the Chevy Chase Club, a complimentary dinner was given to Dr. Johnson by members of the Medical Society of the District of Columbia as a testimonial to his having attained the age of seventy years and to his fifty years of practice, from which he retired in 1913.

The dining room of the Club was tastefully decorated. There were about eighty persons at the dinner. The speakers of the evening were assembled around the great round table. Dr. Frank Leech, President of the Medical Society, presided. The Reverend Father, A. J. Donlon, President of Georgetown University, asked the blessing. Dr. Leech spoke as follows:

Ladies and Gentlemen, Members of the Medical Society of the District of Columbia, Doctor Johnson: As President of the Medical Society of the District of Columbia it becomes my very pleasant duty to preside at this dinner to our very distinguished fellow member.

Any words that I might say would not express the great pleasure it is for us to be thus able to show our slight appreciation of what Dr. Johnson has been to our Society and to the Medical profession, not only of Washington, but of the whole country, for the past fifty years. You will hear from other members in a few minutes in regard to some of his many excellent attainments both as a surgeon and as a man.

Personally, I wish to say that "we come not here to bury him, but to praise him," and wish him many more years of continued good health. I am sorry that I am not to be called on to respond to the toast, "Dr. Johnson as a Golfer," for it would do you all good to see the Doctor as he tramps around the links. It is a hobby with him, and I feel with the late Dr. Busey that we should each have a hobby, and what better can a man have than one that keeps him in the open air and sunshine. Is it any wonder that our friend looks so young and active? I am sure



DR. JOSEPH TABER JOHNSON.

he will tell you that golf is what keeps him in such youthful condition and will recommend it, not only to the middle-aged, but also to the young.

I am particularly pleased to have the honor to number Dr. Johnson among my friends and to be in the position to felicitate him on this the fiftieth anniversary of his entry into the field of medicine where he has earned so many worthy encomiums, and it is my sincere wish that he will live to be present at many more dinners to those of us who are his juniors, and continue to enjoy the excellent health of which he is now possessed for many years to come.

However, I was not supposed to make a speech, but to introduce the Toastmaster of the evening, and consequently it gives me further pleasure to perform this duty. We in the Medical Society are fortunate, not only in the possession of able medical men, but also of good speakers. In this number one stands out preëminently as a silver-tongued orator, and those who have once heard his words of eloquence are always glad of the opportunity to listen to him again. I feel sure that when he has made his remarks and introduced the speakers who are to follow, we will all go home happy in the thought that in Washington the medical man can do more than practice medicine, and it is not necessary to go out of our own Society to get oratorical talent. I now take great pleasure in calling on my very good friend and fellow member, Dr. Joseph Stiles Wall, to take charge as Toastmaster of the evening.

The Toastmaster: This club [wielding an abbreviated golf club] should be used upon the last speaker for giving voice to such sentiments! This gathering is in no sense to be a party for obsequies,—I think that was the word used,—it is to be a Hallowe'en party with our beloved colleague as our guest.

Speaking of the ancient and honorable game of golf, you know that golfers, tramping their weary way over the wastes of the fair green, toiling beneath the scorching sun, have constantly in mind the delicious dream of a haven of rest at the end of their journey. This charming oasis is a land flowing with milk and honey; soft-footed minions wend their way hither and thither among the palms, bearing aloft tinkling glasses of refreshment for the weary dust-stained travelers. It is called the "nineteenth hole." So around this nineteenth hole we are gathered tonight to do honor and homage to our colleague on the completion of fifty years in the practice of medicine. Nor does one have to know how to play golf, to foregather at this oasis.

In going over the list of those who will speak to us, I notice the preponderance of those who in golf parlance are known as

"duffers," but if duffers at golf, they are mighty in the wisdom of medical lore, and as orators they have no peers.

There is one among us of whom we should all be afraid. He knows of all our shortcomings, of our childhood days, and early pitfalls,—in a word, of our past, be it good or bad. He is our able historian and should, in natural sequence, first address us on the life and works of our guest. I take pleasure in introducing Dr. D. S. Lamb.

Dr. Lamb said: Doctor Joseph Taber Johnson was the son of Lorenzo Dow and Mary (Burgess) Johnson; grandson of Jeremiah Johnson, a soldier in the war of the American Revolution, and a descendant of John Alden and Priscilla Mullens of the *Mayflower*. Dr. Johnson was born June 30, 1845, in Lowell, Mass. Lowell is distinguished for two things, the birth of Dr. Johnson and Ayer's Cherry Pectoral.

He attended the Rochester Academy, Plymouth County, Mass., 1855–59, and Columbian College, Washington, 1860–62. Studied medicine with Dr. Wm. G. Palmer, of Washington, and graduated at Georgetown Medical School in 1865. He afterwards continued his studies with Dr. Austin Flint, of New York City, attending Bellevue Hospital Medical College, where he graduated in 1869. In 1889, also, he received from Columbian College the degree of A.M. In 1870 he went to Europe, to Vienna, and in 1871 was given a diploma in Obstetrics at the great Vienna School. In 1890 he was given the degree of Ph.D., and LL.D. in 1913, at Georgetown University. He was at one time President of the Alumni Association of Georgetown University and also at one time President of the Alumni Society of Bellevue Hospital Medical College.

For some years Dr. Johnson was connected with Howard Medical College and the Freedmen's Hospital. June 17, 1867, he was elected Professor of Obstetrics and Diseases of Women and also taught Materia Medica during the first session of the School. In 1871 his chair was enlarged to include Diseases of Children. He was Secretary of the Medical Faculty from 1868 to 1873. He had charge of the Obstetrical and Gynecological ward of the Hospital from 1868–72, serving as Acting Assistant Surgeon, U. S. A., the Hospital being then under the care of the Surgeon General of the Army. He was also Obstetrician and Gynecologist to the Hospital from 1869–73.

In 1874 Dr. Johnson became connected with the Georgetown Medical School and was President of the Faculty for about 25 years. He served as Lecturer on Obstetrics and Gynecology till 1876, when he became Professor of Obstetrics and Diseases of Women and Infants. Later he was appointed, 1895, Professor of Gynecology and Abdominal Surgery. He resigned in 1913,

and was appointed in 1914 Emeritus Professor of Gynecology and Abdominal Surgery. He also became connected with the Georgetown University Hospital; was President of the Board and Gynecologist for fifteen years.

In 1887 Doctor Johnson built for himself, at 1728 K Street, Northwest, a Sanatorium for gynecological cases. After many years of success, he gave it up in 1906.

He was Gynecologist at Columbia Hospital for Women, this city, for two years; and to Providence Hospital, twelve years. Was Consulting Gynecologist to Central Dispensary and Emergency Hospital for ten years. He was one of the founders of the Episcopal Eye, Ear and Throat Hospital; of the Washington Obstetric and Gynecological Society, of which he was President in 1888–9; also one of the founders of the American Gynecological Society, of which he was President in 1898–9, and he was Secretary and Editor of its Transactions in 1888–91. He was a member of the Southern Surgical and Gynecological Association, President in 1898–9, and was made an Honorary Fellow in 1913; was elected a Fellow of the British Gynecological Society in 1886. He was also a member of the Massachusetts Medical Society, of the Medical Society of Virginia, of the American Medical Association, of the Washington Philosophical Society and of the Anthropological Society of Washington. He was the first physician to the St. John's Orphanage and also the Woman's Christian Association Dispensary.

Dr. Johnson was elected a member of the Medical Association of this District October 5, 1869, but postponing too long the required signing of the constitution his election was declared void April 5, 1870; was reëlected October 3, 1871. He was elected a member of the Medical Society of the District May 1, 1867, resigned June 8, 1870, and was reëlected October 1, 1873. He was elected a member of the Medical and Chirurgical Faculty of Maryland in 1890. He was President of the Medical Society of the District in 1887, and while President made a decision that a call for the yeas and nays would require an affirmative vote of one-fifth of the members present. This is probably the only decision ever made on this subject in the Society. He was Vice President in 1894; a member of the Board of Examiners of the Society in 1878–80 and again 1882–5; and a member of the Committee on Directory of Nurses in 1901. He was also a member of the Board of Examiners for registration of physicians in this District for seven years, and President of the Board five years. He is a Fellow of the American College of Surgeons and is now a member of its Board of Governors. In June last he was elected by the Georgetown Alumni a member of the Board of Regents of Georgetown University.

Dr. Johnson wrote the chapters on Diseases of the Ovaries and

Tubes, in Dennis' System of Surgery, and also the chapter on Ovariotomy, in Reed's Diseases of Women; also papers and addresses too many to mention; and he has opened the abdomen for surgical work over three thousand times.

Dr. Johnson was married in 1873 to Edith Maud Bascom, daughter of Professor W. F. Bascom, of Washington. She died in 1905. In 1911 he married Mrs. Mary Elizabeth McCann, widow of Admiral W. P. McCann. Dr. Johnson's son, Dr. Loren Bascom Taber Johnson, is a member of this Society.

Dr. Johnson has also been a member of the Cosmos Club since 1882, and President of the Washington Golf and Country Club since its organization. In 1907, when he retired to his farm across the river, he resigned his membership in the Metropolitan and University Clubs.

The Toastmaster: I knew that the last speaker would fulfill our expectations, and he did. Furthermore it is now clearly apparent why our distinguished guest throughout his life has shown two marked characteristics,—honesty and diffidence. Honesty, because as a child no doubt he had instilled into his young mind the story of Washington and the cherry tree, having been brought up in an atmosphere of cherry pectoral, as Dr. Lamb has told us, and in later years having chosen for his residence a home amid a Dale of Cherries not far distant. Diffidence, because he directly descends from one whose temerity caused Priscilla to say: "Why not speak for yourself, John!"

In our Society we have solved the perennial question "what to do with our ex-presidents,"—we compel them to make speeches upon festive occasions such as this. So we are now to hear from one of our honored former officers, one whose learning and attainment and pungent wit are hidden behind a countenance of such placidity as to be most deceptive. But appearances are always deceptive! We will now have the pleasure of hearing from Dr. Balloch as a representative of Howard University.

Dr. Balloch said: I think that we medical men honor ourselves in honoring those of us who have grown old in the practice of our profession. One seldom hears of a lawyer or a clergyman being honored for fifty years of professional work, but few doctors escape some recognition of a like period of service. With our German confreres this recognition takes the form of a book, a *Festschrift,* made up of papers contributed by his friends and former pupils. With us it takes the form of a dinner. As no one ever reads one of these *Festschriften,* a dinner is perhaps a more agreeable if not so heavy a substitute.

Wordsworth, in one of his most beautiful poems, asks "Who is the happy warrior?" Just now that question would be hard

to answer, especially in Europe, where the only truly happy warrior would seem to be the dead one. In a similar way I have asked myself often, "What is the ideal life for a physician?" I have answered it to myself by assuming that the ideal physician would be one who started on his professional career with a full equipment of body, mind and heart; that during that career he should have an abundance of congenial work and that by means of such work he should accumulate a competency which should enable him to pass the evening of his days in the pursuit of some hobby which would serve to pass the time pleasantly and healthfully. I think that Dr. Johnson has fulfilled these requirements in an eminent degree. He has worked hard. I have heard it intimated that Dr. Johnson was fortunate in being the pioneer gynecologist in this city. Not that real gynecologists are any too plentiful now, for I do not consider that every one that can open the abdomen of a woman is a gynecologist by any means. I do believe, however, that Dr. Johnson would have held his own even in competition with the gynecologists of today. Fortunately he is able to pass the evening of his days in the cultivation of golf, and I am sure that anyone who could see him on the links of the Washington Club, in company with such eminent golfers as President Wilson and Dr. Mackall, would feel satisfied that he was passing his time both agreeably and with benefit to himself.

Therefore, Dr. Johnson, in behalf of Howard University, I extend to you her sincere and hearty felicitations on your having reached the seventieth anniversary of your birth and on having completed fifty years of practice in a way alike honorable to yourself and helpful to the community in which you have lived. May we be permitted to celebrate the diamond anniversary of that event as we now do the golden.

The Toastmaster: We will now have the privilege of listening to another ex-president. He has been honored by the highest office within the gift of the Society and has merited this preferment because of the high esteem in which he is held by each and all of its members. With a scientific mind of extraordinary development, he possesses the ability to juggle fats, proteids, carbohydrates and calories, until the result resembles a club sandwich. They are as mere chaff in his facile hands. On behalf of the George Washington University, we will now have the pleasure of hearing from Dr. J. B. Nichols.

Dr. John B. Nichols recalled the prominent part Dr. Johnson had taken in the proceedings of the Medical Society and also the conspicuous place he held in the esteem of large numbers of the residents of Washington for the services he had rendered them.

THE TOASTMASTER: Our distinguished guest has always been the picture of health and, insofar as I am aware, but once has there been exception to this manifest well-being on an occasion when he fell from grace into the hands of a surgical colleague, and was, in the words of Shakespeare, "hoist with his own petard!" He has ever been an earnest advocate of the joy of living and an apostle of the gospel of the out-door life. This banquet board in front of me resembles somewhat the time-honored "squegee board," and there can be no doubt but that its quiverings are transmitted from the shaking knees of the next speaker who sits not far off. In spite of these suspicions, I will introduce to you one who stands foremost among us for all that makes for health and well being, Dr. William C. Woodward, who will speak to us as a representative of the Georgetown University.

Dr. Woodward said:

Mr. Toastmaster, Dr. Johnson, and fellow members of the Medical Society: The Toastmaster has, he tells you, taken his cue to introduce me as the next speaker from the tattoo my quaking knees have been beating beneath the table, and I cannot deny the accuracy of his observation or the keenness of his deduction. Ordinarily, I acknowledge, I rise upon an occasion of this kind without embarrassment; for me to pretend otherwise would be mere mock modesty. But now the words come unwillingly, in the fear that they may not fitly voice the sentiments of the institution on whose behalf I am called upon to speak, nor do just honor to the guest of the occasion.

It has been without jealousy, but with feelings of heightened affection and pride, that we of Georgetown University have heard the kindly tribute offered by those who have spoken on behalf of George Washington University and of Howard University, with each of which Dr. Johnson has borne intimate personal relations at one time or another in his career. But it was in Georgetown's cloisters that his professional life began; it was from her halls that he was first graduated a doctor of medicine; and it is in her service that the best and the busiest years of his life have been spent. Truly, then, he is bone of her bones, and flesh of her flesh; and the love and admiration so justly laid before him are as grateful to his Alma Mater as is to any other mother the praise given her son.

A few days ago there marched up The Avenue the remnant of the Army of the Republic that half a century before passed in the grand review on the same great boulevard. Time had thinned the ranks to a mere thread, and his hand had borne heavily upon the few that remained to join in the event. The men before you were old men, many of them infirm with age. And yet it was in the very year of that grand review, full fifty years ago, in 1865, that Dr. Johnson was graduated from the medical school

of the University of Georgetown. Inconceivable it seems, as we look upon him now, erect, vigorous in mind and body, and still wearing upon his face the smile of early manhood; yet such is the fact. Two years before, a youth of eighteen, he had entered the medical school, then located on F street, next the corner of Twelfth. It was not, it must be admitted, such a medical school as you would look for today, but it was in keeping with like institutions of that time. And whatever was lacking in the way of microscopes, incubators, sphygmographs, and other apparatus deemed essential at the present day, was amply compensated for by the interest, intelligence, and zeal of the faculty. If we judge the school by the men it graduated, we shall find no fault with it. For young Johnson it did more than even the very best schools of the present day do for ninety-nine per cent. of the men they graduate; for it sent him into the world thoroughly dissatisfied with the knowledge and skill he then had, and determined to acquire more. Perhaps that was the very cornerstone of the foundation upon which his success was built.

The next two years found Dr. Johnson in New York City, studying at what was then one of the greatest centers of medical education in America, the Bellevue Hospital Medical College. It was no six weeks' post-graduate course he was pursuing, such as are so often deemed ample at present, but the regular course of study leading to a degree. In 1867 that degree was conferred, and Dr. Johnson returned to Washington and began the practice of his profession.

The next two years saw Dr. Johnson still studying, despite the burden of his professional duties, and we find him, in 1869, in the graduating class of Columbian College, receiving the degree of Master of Arts. It was during this period, in 1868, that there happened to Dr. Johnson one of the most fortunate incidents in his medical career—fortunate for him, and even more fortunate for the medical profession—for he became a teacher of medicine. To any earnest student of medicine such a position means not an opportunity to earn money, nor even an opportunity to enlarge practice. It means an opportunity to learn. Certainly this is what the professorship of obstetrics and diseases of women and children, at the Howard University, to which he was then appointed, meant for Dr. Johnson. But even the opportunities thus afforded failed to satisfy his desire for knowledge and greater and greater skill. For in 1870, we find him in Vienna, pursuing the study of his chosen specialty, obstetrics, and receiving a certificate of proficiency in it; and a trip to Europe and a course of study there meant much more in those days than it does now, when European travel is almost universal and nothing short of a widespread war can prevent it. Dr. Johnson's connection with Howard University terminated in 1873.

You all realize, I am sure, that what I have related of Dr.

Johnson's early medical history is a mere repetition of what has been told you by one of the speakers who preceded me. I have ventured, however, to repeat it, even at the risk of wearying you, in order to point out the substantial character of the foundation upon which Dr. Johnson's medical career was built. No sacrifice of time or energy was too great even in those early days if it gave promise of adding to his professional ability.

Dr. Johnson's work as a student and as a physician, and his ability as a teacher, had not passed unnoticed, and in 1874 he was appointed lecturer on obstetrics and diseases of women, in the medical school of the University of Georgetown. This marked the beginning of his connection with the faculty of that institution, which has continued ever since. Two years after his first appointment four of the faculty retired from active service, as emeritus professors, among them the professor of obstetrics and diseases of women and children. Dr. Johnson was immediately promoted to fill the vacancy, and from that time until his retirement from the active faculty, in 1912, he was continuously engaged in the training of embryo physicians in the science and art of obstetrics, gynecology, and abdominal surgery. His title and work varied, of course, with the advances in the science and art of medicine, but his course remained always a feature of the school's work. Diseases of children were assigned to another chair, not long after Dr. Johnson's appointment. Later, obstetrics went the same way. Then, in 1896, in harmony with prevailing medical fashion, Dr. Johnson, who had been simply professor of gynecology, became professor of gynecology and abdominal surgery. It was with the title of professor of gynecology and abdominal surgery, that, in the year 1912, to the great regret of the faculty, alumni, and the students under him, he retired from active participation in the affairs of the medical school. When I speak of Dr. Johnson's retirement from the active work of the school, I speak advisedly. For during the great part of his connection with the University not only was he engaged in didactic and clinical teaching, but as president of the medical faculty, from 1883 to 1888, and from 1898 to 1901, and as vice-president, from 1901 to the date of his retirement, he assumed much of the burden of the executive work of the medical school; and as chairman of the committee appointed in 1897 to establish the Georgetown University Hospital, and for many years as chairman of the Committee on Hospital Administration, he gave unsparingly of his time and strength to the upbuilding and maintenance of that institution, the success of which has been due in no small measure to his efforts and interests.

Too often recognition of merit is accorded only after death. It is pleasant, therefore, to record the fact that Dr. Johnson's Alma Mater has not been unmindful of the service he has rendered. In 1889 she conferred upon him the degree of Doctor of

Philosophy, and in 1914, after he assumed the post of emeritus professor, he was honored with the degree of Doctor of Laws.

So far we have dwelt in the cold and formal atmosphere of professional life. But, however much we have been compelled to say in Dr. Johnson's praise when we have measured him according to the standards there prevailing, it may be questioned whether it is in that aspect of life that he has been most highly regarded, and whether it is as a physician, obstetrician, gynecologist, abdominal surgeon, teacher, and hospital organizer that he himself would most desire to be remembered. His prayer, I imagine, would rather be the prayer of Abou-Ben-Adhem: "I pray thee, then, write me, as one that loves his fellow men." And such we find has been his life. Whether in the intimacy of private intercourse, or in the professional relations of the sick room, the dispensary, or the hospital ward; whether in his relations to the students in the lecture hall and amphitheatre, or in his relations to his fellow practitioners, his peers, in the consulting room or in the directors' and staff meetings; whether in his relations to the sister in charge of the hospital or to the student-nurse in the operating room, it has always been the same kindly, considerate Dr. Johnson. If within the sacred confines of a faculty there were at times intimations that Dr. Johnson had been too considerate of his students and that he had out of the goodness of his heart given passing marks to some whom possibly a stricter judge might have refused to pass, Dr. Johnson has always been able to convince his associates that his students were more successful in their study of his branch than they were in the branches those associates taught, merely because of the superior educational methods employed by Dr. Johnson. I have no doubt that the delightful way in which Dr. Johnson was always able to present his subject, often enlivened by stories and anecdotes, that held the interest of the students, contributed materially to the interest, willingness, and success of those who pursued courses under him.

Now, having laid aside happily all of the cares and responsibilities of the practice of obstetrics, gynecology, and abdominal surgery, Dr. Johnson is limiting his activities to that other field in which he has so long been an adept—good fellowship; and he, we understand, has established headquarters at a country club not far away for the particular practice of that art. Wisely has he selected, too. For the practice of obstetrics, gynecology, and abdominal surgery make a man old, while the practice of good fellowship keeps him young—and no one can conceive of Dr. Johnson as otherwise than young. The pathologist may tell you that a man is as old as his arteries, but I, as a sanitarian, believe the pathologist is wrong. Disregard the age of a man's arteries; a man is as old as his heart, and no older. And measured by

that standard, there is as yet in Dr. Johnson no sign of age. He is in that happy class to which the great poet-philosopher of our profession himself belonged, and which he has so charmingly described something as follows:

We've a trick, we young fellows, you may have been told,
Of talking (in public) as if we were old;—
That boy we call "Doctor," and this we call "Judge;"—
It's a neat little fiction,—of course it's all fudge.
* * * * * *
You hear that boy laughing?—you think he's all fun,—
But the angels laugh, too, at the good he has done;
The children laugh loud as they troop to his call,
And the poor man that knows him laughs loudest of all!

Yes, we're boys,—always playing with tongue or with pen,—
And I sometimes have asked,—Shall we ever be men?
Shall we always be youthful and laughing and gay,
Till the last dear companion drops smiling away?

Then here's to our boyhood, its gold and its gray!
The stars of its Winter, the dews of its May!
And when we have done with our life-lasting toys,
Dear Father, take care of thy children, the Boys!

On behalf of these assembled friends, Dr. Johnson; on behalf of your innumerable grateful patients who are unable to be here in person tonight; on behalf of your ex-students, among whom I am proud to be numbered, scattered over the entire civilized world; on behalf of your associates in the medical profession; on behalf of the University of Georgetown, which you have served so long and so well, I congratulate you. I wish you long continuance of health and strength that you may reap on this earth some small part of that reward to which your labors rightly entitle you, ere you pass to that everlasting and greater reward that must be yours in the Great Beyond.

The Toastmaster: Notwithstanding the recent results in New York and New Jersey, be it said to the glory of the medical profession that the woman physician was early admitted to equal rights with the man within the ranks of our fraternity. It was only natural that our women practitioners should early turn their attention to gynecology as a specialty and that their interests should be closely identified with those of Dr. Johnson as an exponent of a similar branch in medicine. When we speak of women physicians we naturally think of one who has attained a

position of such eminence in their ranks that any introductory remarks are really unnecessary. Let me present Dr. Mary Parsons, who will address you on behalf of the women physicians of Washington.

Dr. Parsons said: I am glad indeed that we no longer follow the old custom of waiting until a man is dead before we say the kind things we have heard about him, the kinder things we think about him, the dear things we know about him. I am glad we speak out as man to man while he yet hath ears and heareth. I am also glad that we have not adopted the oriental custom of bearing our choice viands and libations to be spread upon his grave, a feast for the birds of the air and the beats of the field, but an economic waste and a gastronomic disappointment.

The women have personally much occasion to thank the Doctor for rendering our participation in these festivities a possibility, as he has, from the beginning of his medical career, persistently believed in and endeavored to secure simple justice for all, irrespective of sex prejudice. My personal gratitude to the Doctor extends from a dim and distant past, bounded by more years than either he or I would care to enumerate. It began with the relationship of professor and pupil, and continued in the same spirit for some years after my graduation when, as you all know, it is even more desperately needed and much more keenly appreciated.

My dear friend in those early years of practice was Dr. Mary Spackman, the first woman graduate and the first woman practitioner of the regular school in the District. A frail, delicate woman of the highest culture and refinement, a finished scholar, an ardent student, imbued with a spiritual courage that could have carried her into the lion's den or through the fiery furnace had she believed any other woman could be benefited thereby.

Left a widow at an early age, with two young children entirely dependent upon her exertions, she soon learned the cruelty and injustice of the world when one enters upon a hand-to-hand fight for survival. And that knowledge, which pierced her very soul, stimulated her to endeavor far beyond her physical strength, and foreign in every particular to the traditions of her birth and training. Dr. Spackman entered the class, the only woman in it, under conditions that appealed to all the chivalry and all the manhood contained in a man's soul. The faculty, as one man, responded to that mute appeal, and every opportunity was given her for perfection in her medical studies and every form of training that would secure to her manual skill and dexterity.

Dr. Johnson was for some years our consultant at the Women's Christian Association, where we were carefully trained in the dis-

eases of old age, at a time when little attention was being paid elsewhere to their distinctive characteristics. We had there, also, a home containing from forty to sixty children, in which we were also trained before Pediatrics had become specialized. With the inconsequent enthusiasm of the young practitioner, we undoubtedly made heavy demands upon his time and patience, utterly oblivious as we were to divisions of time or states of weather.

The poor Doctor may have added some stars to his golden crown in those days. As I have already said, Dr. Johnson not only responded faithfully and cheerfully to our many demands, but also gave us opportunities to see and profit among his own cases, such as were unusual or specially instructive. Through his kindness we saw the first *successful* ovariotomy performed in the District, though it was a wonder we did not all die from inhaling the carbolized vapor which was used as a means of sterilization. We saw him do the first reparative work that was done in the District upon a private patient of Dr. Spackman's, and a little later the first oöphorectomy. Some time in the early '80s Dr. Johnson became one of a Board of Managers and Consultant for the Woman's Dispensary, the first institution established in the District for the treatment of women and children by women physicians, conducted at that time by Drs. Rice and Sumner, and after the death of Dr. Rice, by Drs. Sumner and Heiberger. This was an institution which did much good work, not only to patients, but also in serving as a training school for recently graduated physicians, one of whom, Dr. King, a young Chinese woman, graduate from a Philadelphia college, came here for the express purpose of taking a post-graduate training for six months, which was given her by Dr. Johnson with especial reference to the demands which would be made upon her on her return to China. She was the first woman to enter upon regular medical practice in China, and by her successful work opened the field to the medical missionaries, by whom a most wonderful work has been accomplished.

As long as Dr. Johnson remained upon the board of the Woman's Dispensary, its work was outlined upon the lines on which it was founded. So it has gone on through the years, good work, cheerfully given, wherein the need seemed most urgent, whether individual or collective. Ever a friend to the young graduate, ever ready to extend a helping hand to those who had not gained secure balance upon untried feet.

Now, through the smiles of kindly fortune he has entered the leisure class and has time to enjoy to the full the sunset glories of a life work that bears no taint of selfishness to tarnish it.

With due apology to the shade of Whittier, I will misquote a few lines which I am sure you will all endorse:

"Grateful smiles my lips unseal,
As in memory I blend
Old-time teacher, present friend.
Threshing times, neglected sheaves,
Gathering up the scattered leaves,
Questioning the stranded years,
Waking smiles and sometimes tears,
As thou callest up again,
Shapes the dust hast long o'erlain.

Old friend, kind friend, lightly down
Drop time's snowflakes on thy crown.
Never be thy shadow less,
Never fail thy cheerfulness.
Care that kills the cat shall flee
Miles and miles away from thee.
Good brown health and ready wit
Ever at thy threshold sit.
Long and happy days be thine!
And when thou art called at last
To the friendships long since past,
Not as stranger shalt thou come,
Thou shalt find thyself at home."

THE TOASTMASTER: I know of no more faithful wheel-horse of the Society than Dr. G. Wythe Cook. To him now falls a very pleasant office. He has ever been an untiring worker in the interests of this Society. As a former president, for many years as chairman of the Executive Committee, it has been his lot to care for much of the important business of the Society, and only this year we sent him as our standard bearer far to the western coast to represent us in the councils of the American Medical Association. Tonight he essays a new and pleasurable rôle, that of "Ganymede;" was he not the cup-bearer of the gods? Dr. Cook.

DR. COOK said: On a pleasant day in May, when the committee from the Medical Society went to convey greetings to Dr. Johnson from his medical friends, and to tell him of our intentions toward him, we found him beneath the shade of a widespreading tree in his rural retreat, calm and serene, gazing over hill and dale, enjoying the zephyrs that floated in on him. Having acquainted him with the object of our visit, it was refreshing to witness the pleased expression on his genial face and to hear his words of appreciation of the compliment that we proposed.

He said that since he had retired to his sylvan home he had converted his scalpels into pruning knives and his catheters into

milking tubes. I do not mean to say that Dr. Johnson used his pruning knives himself, but that they had been used with skill and judgment was apparent in the well-trimmed shrubbery around. Neither do I insinuate that he personally used the milking tubes, but that they had been carefully manipulated, the other members of the committee will substantiate, because we all enjoyed delicious draughts of the lacteal fluid given us. My own impression was that there was some one else in the house who had a fine hand in the direction of the domestic machinery, for none but woman's taste could account for the delightful charm of the surroundings.

Now, Dr. Johnson, your friends in the medical profession of Washington have held a consultation in your case, and in the plenitude of their wisdom and cordiality have decided that the right and proper thing to do for you, is to *cup* you. I will say, however, for your comfort and peace of mind, that we do not intend to scarify you; we propose only to *dry* cup you, for anything more would manifestly be inharmonious to one who resides in a dry State. I am one of the boys, according to the Toastmaster, the beautiful boy, Ganymede, the cupbearer.

I have the great honor and the very pleasing privilege of presenting to you this token of the esteem and good will of your many friends in the medical profession here assembled.

The Toastmaster: Ladies and gentlemen—Our guest, Dr. Johnson.

Dr. Johnson said: Mr. President, Mr. Toastmaster, Ladies and Gentlemen: With a heart filled to the bursting point with emotions of gratitude and appreciation for the kind words which have been spoken around this table, and for the good things provided on the table, here tonight, it can hardly be expected that I can find words to express my thanks to my associates of the Medical Society, especially when I realize that I have been complimented by your speeches and by this dinner far beyond my just deserts.

I have often thought when I have heard remarks at memorial meetings, recounting the good deeds and praiseworthy acts of departed members or friends, how much better, as Dr. Parsons suggested in her beautiful speech, it would have been, if some of these good things could have been said, such as we have just heard, directly to this member or friend, before his final departure, to cheer and sweeten his declining years, as he advances toward that bourne from which no traveler returns.

This thought has been so exemplified, illuminated and demonstrated here on this complimentary occasion, that the recipient of your kindness finds himself so embarrassed and overwhelmed

by your generous references to his professional work and associations during the past fifty years, that he feels absolutely unable to do full justice to the subject in anything he might be able to say in the way of thanks and appreciation. So that perhaps the *memoriam* plan has its advantages, the chief of which might be the inability of the subject to talk back, or as we say in our medical faculty meetings, to close the debate.

I feel somewhat as our dear friend Dr. Ford Thompson did on a similar occasion, seven years ago, when he said that his own mother would not have recognized her son in the complimentary description given of him by the speakers; and I have been feeling as Dr. Thompson said that he felt in another particular, which was, as the time drew near, his doubts increased as to whether the occasion required a formal written address upon the history of surgery in Washington during the preceding fifty years, or whether he should trust to the inspiration of the hour. I believe that he decided upon the latter course of procedure, and very wisely, too, it seems to me, as no man under these very similar circumstances could know beforehand, except in a general way, what would be said, and he could not therefore write an address which would be appropriate and fit naturally into the unusual and very personal situation.

Mention has been made all too kindly of my work during the best part of the last half century as a gynecological teacher and operator. No one knows and regrets the imperfections of that work more than I, though from the evidence just now presented, a stranger might form an opinion that it had met with some degree of success. Which kindly evidence will greatly cheer my drooping spirits as I sit on the porch of my country home and think how much better that work and teaching might have been done.

It is really a great thing in this life to occupy the position of a teacher of the rising generation of medical aspirants, to aid in molding and developing their lives and characters, to assist in starting them aright in their professional careers, and to impress on them that kind of ethics that is based on the teachings and practice of the golden rule; this, of course, in addition to the technique of one's particular department of learning.

But the discussion of this and kindred subjects, such as the progress of gynecology and medical education during the past fifty years, seems to be barred in the keynote speech of our distinguished President, declaring against all solemnities, and stimulating expressions of good fellowship and kindly feeling. By this arbitrary decision of the chair, he has cut out more than half of my intended speech, and by this act made it contrary to the inspiration of the hour, which seems to partake more of the

characteristics of the ancient and honorable game of golf than of other more solemn reminiscent and instructive subjects.

In attempting to thank the speakers and you all for your kind words and deeds, I am reminded of the dilemma of the clergyman who had been detained by sickness from his pulpit for several weeks. He had been unable to write notes of thanks to the members of his congregation who had sent him many evidences of their affection and good wishes for his early recovery and return to the sanctuary, and he seized the opportunity of his first appearance to express his thanks to them collectively, and to say how much good cheer and encouragement he had received from their kind messages and gifts that accompanied them, and while he would not take the time to enumerate all of them, he would say that he felt especially grateful for the delicious brandied peaches, which had aided him so much in drowning the taste of the medicines that he had been obliged to swallow, and he was not only grateful for the peaches themselves, but for the spirit in which they were sent. All the speeches this evening have been peaches; not a single lemon in this garden of love; and the spirit in which they have been made leads me to say that I am in love with you all.

This beautiful complimentary occasion is really more an affair of the heart and the stomach than of the intellect or the brain, and I cannot refrain from saying that the dinner and your many and wholly undeserved expressions of kindness to me will ever remain among the sweetest memories of my life.

One cannot, however, take an affair of this kind wholly to one's self. It is the happy custom of this Society, as I understand it, to extend this compliment to its members who have practiced medicine with credit and efficiency for fifty years in this city and have also attained the age of seventy years. It is a curious thing that in a medical society nearly one hundred years old this interesting conjunction of events has only occurred four times in its history, and it is a matter of great pride as well as happiness to be one of the "old four" to whom this compliment has been extended.

Many *in memoriam* meetings have been held in which we have eulogized the lives of departed members as practitioners, teachers, authors, citizens, special experts, and kind-hearted friends, but just this kind of meeting of congratulation and compliment has occurred only on the average, as we say in golf, once in twenty-five years, where in the kindness of your dear hearts you say these things to a man's face to cheer his heart through all the remaining years of his life.

And now, Mr. President and friends of the Medical Society, in addition to all the other good things said and done this evening, comes this beautiful and costly loving cup, presented in your

name in such kindly and expressive words by Dr. Cook. My heart is too full to tell you of my grateful appreciation of this added evidence of your kindness, which will be cherished with pride throughout all the remaining years of my life, and by my children and children's children. May God bless you, each of you, with fifty years of successful and lucrative practice, and through three-score years and ten with health, happiness and prosperity.

THE TOASTMASTER: Dr. Adams has asked me to announce the receipt of a message from Dr. J. Ford Thompson telling of his great regret at his inability to be present this evening, and sending his good wishes and felicitations to our honored guest.

Dr. Johnson, in your favorite game of golf there are many "lies!" Golfers speak of them as good lies and bad lies; but tonight, around this nineteenth hole, you have heard said that which is the truth, the whole truth, and nothing but the truth. We stand adjourned.

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